

Chronic Constipation in Pediatrics - Not Always a Trivial Discomfort

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Case Report

Gastrointestinal motility disorders and chronic constipation are common pediatric problems. Symptoms of abdominal discomfort are frequently encountered in the daily practice. Normal peristalsis depends on the interaction between muscles, nerve cells, and tendinous connective tissue of muscularis propria [1].

Constipation is one of the most frequent consultations in the pediatric emergency service and gastroenterology. The symptoms of it can be very variable, including recurrent abdominal pain, abdominal distension, chronic diarrhea, secondary encopresis and even urinary symptoms such as enuresis and urinary tract infections (UTI).

95% of the cases presenting with constipation have an idiopathic origin. They are classified as either functional (95% of the cases) or organic. The organic cases, are further divided into disorders of different nature: metabolic, endocrinal (hypothyroidism, diabetes insipidus, hypercalcemia), anal lesions, drug-induced disorders, myopathies (muscular dystrophies, megacystis, microcolon syndrome, secondary ischemic myopathy), collagenopathies (desmosis, connective tissue disorders) or neurogenic (Intestinal dysganglionosis such as Hirschsprung disease, hypoganglionosis, ganglioneuromatosis, neural dysplasia, spine disorders,...).

The diagnosis is a combination of a profound anamnesis, radiologic findings and anorectal manometry. However the final "gold standard" requires histopathologic evidence.

We report a case of a 13 years old teenager who presented in the emergency room with pollakiuria, diminished stream flow for the last two days and abdominal distension for one week. He refers long term treatment for encopresis. During the physical exam an important abdominal distension with a painless left abdominal mass stands out (Figure 1).

Under suspicion of an abdominal tumor and not being possible to perform an abdominal ultrasound, an abdominal X-ray was performed instead. Abundant fecal material was shown in central abdomen reaching the left upper quadrant (Figure 2).

Digital rectal examination revealed fecaloma of hard consistency. The blood test discarded hypothyroidism, celiac disease. The patient was admitted to complete study with barium enema, ultrasound and abdominal CT, which globally demonstrated megarectum-megasigma with big fecaloma (Figure 3).

Enemas and rectal evacuation were started as part of the treatment. Rectal biopsies were performed providing the diagnosis of hypoganglionosis.



Figure 1: Abdominal distension with a painless left abdominal mass.



Figure 2: Fecal material was shown in central abdomen.

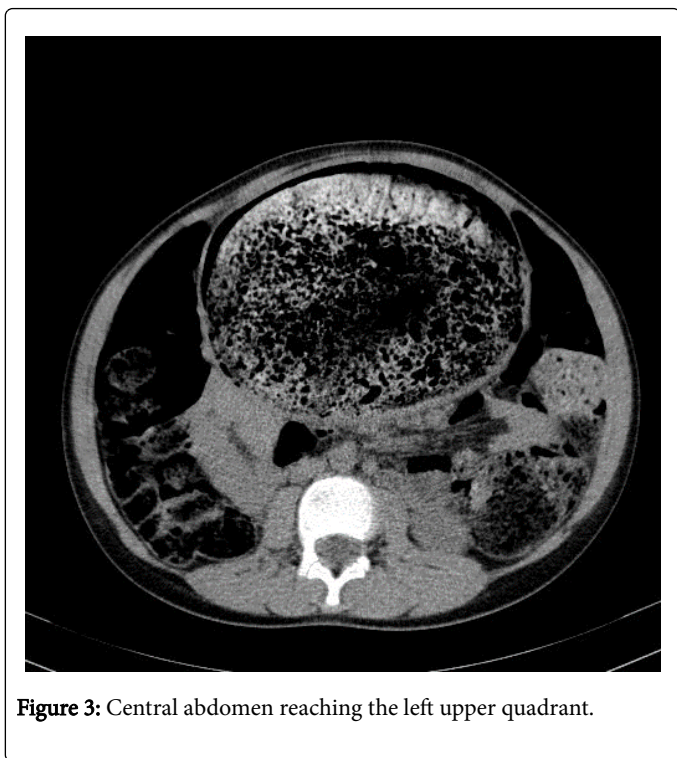


Figure 3: Central abdomen reaching the left upper quadrant.

Hypoganglionosis is a rare dysganglionosis characterized by scarce and smaller ganglionic nerve cells in the intestinal wall. On the other hand, it's important to differentiate hypoganglionosis from Hirschsprung's disease, which is a congenital absence of intramural ganglion cells in the distal bowel. A rectal biopsy is currently the "gold standard" for diagnosing dysganglionosis when clinical symptoms are megacolon [2] and intestinal pseudo-obstruction. The treatment should include a medical and surgical approach [3,4].

References

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