

Rectal Atresia – A Hidden Work of the Nature

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Respected Editor,

Rectal atresia and stenosis are rare anorectal malformations accounting for 1% of the cases. Both conditions are associated with an atretic rectal segment and a normally developed anus [1-2]. Failure to pass meconium, abdominal distention, unwillingness to feed, and vomiting in newborns are signs of intestinal obstruction and require further investigation [3].

Typically, a simple clinical diagnosis of rectal atresia is made by passing a thermometer through the rectum. A positive diagnosis is made when resistance is felt a few millimeters from the anal verge [4]. The clinical diagnosis is then followed by specific investigations for the site and nature of the atresia [1]. Since failure to pass meconium

has varied causes, the timely usage of a thermometer test is more accurate and immediate in the detection of anorectal agenesis than simply observing meconium passage, which may take up to 48 hours in healthy term neonates and even more in preterm neonates. Early diagnosis and surgical referral are imperative to avoid complications and improve the outcome in such cases [5].

We present a case of a full-term male neonate, who was delivered *via* elective cesarean section at 39 weeks of gestation. He developed progressive gross abdominal distension and vomiting after the initial feeds in the first 24 hours of birth (**Fig. 1a**). On examination, the abdomen was distended with palpable bowel loops. The baby had a normal anal opening and genitals (**Fig. 1b**).

We then proceeded with the thermometer test, which ultimately led to the clinical diagnosis of rectal atresia. The test helped us confirm our clinical suspicions. Resistance was felt at 2 cm from the anal verge. We performed a divided high sigmoid colostomy on the third day of life. Subsequently, a few months later a distal loopogram was performed which confirmed the diagnosis of distal rectal atresia with a gap from the anal canal. No fistula was visualized (**Fig. 1c**). Posterior sagittal anorectoplasty was performed at the age of 9 months with an end-to-end anastomosis of the rectum with the anal canal.

In resource-limited settings, where expensive imaging is not possible, physicians have to rely on clinical tests to diagnose and initiate management. We, therefore, recommend primary care physicians, pediatricians, and neonatologists include thermometer tests in routine neonatal examinations and not rely solely on meconium expulsion. Additionally, incorporating this clinical method as a regular part of neonatal examinations could effectively prevent the manifestation of symptoms of intestinal obstruction and mitigate the risk of serious complications.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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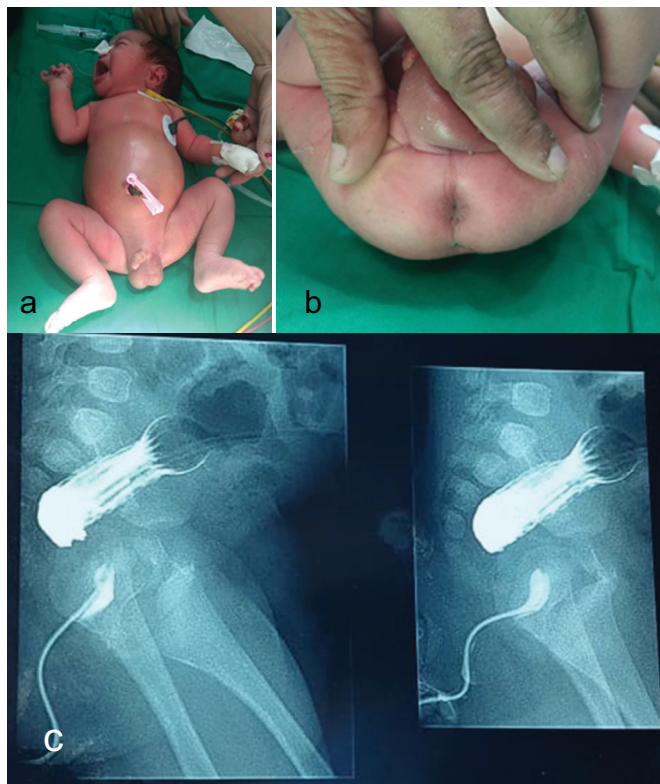


Fig. (1): (a) A 1-day-old child presenting with abdominal distension. (b) On examination, the baby had a normal anal opening. (c) Distal loopogram showing contrast in the rectum which is ending at the S4 vertebra and contrast in the anal canal with a 2 cm gap between them.

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