

Fecaloma Resulting In Bowel Obstruction And Death: Case Report And Review Of Literature

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Citation

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Abstract

Fecaloma is a mass of accumulated fecal matter being impacted most commonly in the sigmoid colon and rectum. It is usually seen in patients with chronic constipation, Chagas disease, and psychiatric illness. Patients can present with non-specific complaints. Conservative management includes laxatives, bowel rest and enema but surgical and endoscopic intervention may be required in some cases. We report a case of fecaloma which led to bowel obstruction. The patient failed both conservative and endoscopic treatment and ultimately passed away. Early diagnosis and management can potentially have a favorable outcome.

INTRODUCTION

The first case of fecaloma was described in 1967 (1, 2). It is defined as a mass of hardened feces most commonly accumulated in the colon or rectum (1, 3, 5). Fecaloma has been described in the literature before. It results from accumulation of fecal material that forms a mass separate from other bowel contents (6, 7). It has been described in patients with Hirschsprung's disease, idiopathic chronic constipation and psychiatric patients (1, 4). Our case has several teaching points and highlights the importance of early detection of these patients which could potentially result in a favorable outcome.

CASE

A 92 year old female with history of hypertension and diabetes presented to the emergency department with complaints of lightheadedness and dysuria. The patient had recurrent urinary tract infections in the last 2 months. She was treated with multiple antibiotic courses. The patient also complained of abdominal pain and distention. She denied hematuria and pyuria. She was alert and oriented on admission. Vital signs were within the normal limit. Abdominal exam was remarkable for distention and hypoactive bowel sounds. The patient had a computed tomography (CT) scan of the abdomen which showed dilated redundant colon consistent with colonic pseudo-obstruction without evidence of perforation. She was admitted and

started on antibiotic for urinary tract infection. Overnight the patient's abdominal distention continued to get worse. She did not have any nausea or vomiting at that time. An abdominal x-ray was obtained and showed large amount of stool in the colon and central small bowel distention suggestive of ileus. The surgery team recommended to continue electrolyte replacement, laxatives, intravenous fluids and diet as tolerated. The next day the patient started to vomit which led to aspiration and the patient subsequently developed acute respiratory failure. She was intubated and was taken to the intensive care unit. An oral gastric tube was placed and large volume of liquid dark brown gastric content returned. Gastroenterology was consulted to evaluate for gastrointestinal bleeding however the patient's hemoglobin remained stable and no active bleeding was noted. The patient was placed on nasogastric tube with intermittent suction. She had no bowel movements and therefore gastroenterology decided to proceed with colonoscopic decompression. The scope was advanced and a large black stone like mass was noted in the sigmoid colon with some degree of colonic obstruction. Attempts were made to dislodge this fecaloma with Roth net but they were unsuccessful. They also attempted to put a snare around fecaloma but that failed as well. The scope was then advanced without air insufflation all the way to the mid transverse colon and a large amount of liquid stool and air was suctioned. The scope was gently removed over a

guidewire and later a 4-French cook medical colonic decompression tube was advanced over a guidewire. The tube was deployed to continue tap water enemas. The patient's abdomen was soft after the procedure. Surgery did not consider the patient a good surgical candidate for removal of the fecaloma. The patient's respiratory status continued to decline ultimately leading to cardiac arrest.

Figure 1

CT abdomen transverse section with noticeable fecal matter and colonic distension

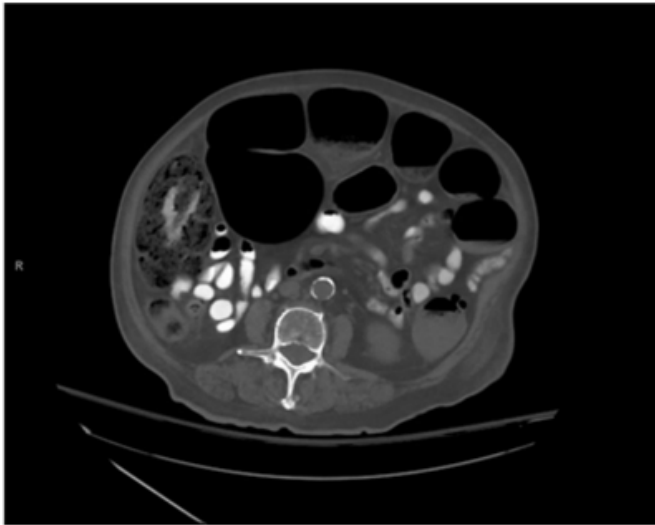


Figure 2

Abdominal CT coronal section showing large fecaloma

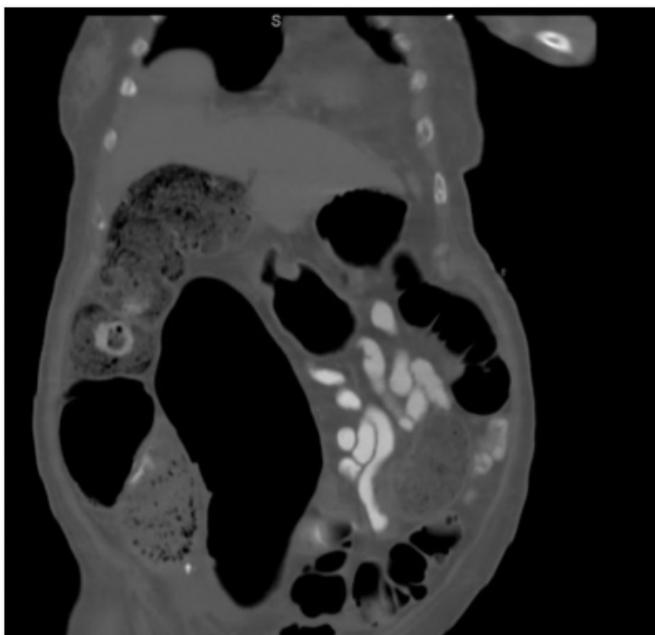


Figure 3

Large gaseous distension of the colon



DISCUSSION

Fecal impaction is commonly seen in the emergency department. However, fecaloma is an extremely rare form of impaction. It is most commonly noted on the left side of the colon (sigmoid, rectum) because the stool becomes firmer and the colon diameter is smaller on the left compared to right but in very rare cases small bowel involvement has been described in the literature (1,3,8). The process which involves its formation includes accumulation of fecal matter in the intestine which then stagnates and increases in volume until the intestine becomes deformed and acquires characteristics similar to those of a tumor (1, 9). It been seen in association with Chagas disease, Hirshsprung's disease, inflammatory disease, neoplasm, chronic constipation, psychiatric patients and elderly institutionalized population (1, 4). Patients with fecaloma usually present with nonspecific complaints such as constipation, weight loss, vague abdominal discomfort after meals, "overflow type" of diarrhea (4). Complications of fecaloma are generally divided in to 2 types: one which results from directly obstructing either colon or small bowel and can lead to perforation, peritonitis, abscess formation and another which

complicates by compressing the adjacent anatomical structures and leads to bladder compression, ureteral obstruction resulting in hydronephrosis, nerve compression resulting in sciatica, or deep venous thrombosis (4,10,11). Management is somewhat controversial. Most of the fecal impaction can be successfully treated conservatively with bowel rest, laxatives, suppository, rectal enemas and manual digital evacuation (1, 3, 4). Endoscopic approach for removal of fecaloma has also been described in the literature (4, 12). Just as in our case, when conservative measures fail or when potentially dreadful complications such as bowel perforation, peritonitis or abscess formation develop, the patients benefit from surgical intervention. Unfortunately, in our case the patient was not a good surgical candidate. Surgical procedure generally involves either exploratory laparotomy or laparoscopy followed by removal of the fecaloma and resection of the involved colonic segment (1, 4). Patients who were successfully treated need to be closely followed up and treated with stool softeners. Emphasis on proper dietary habits which includes high fiber diet and adequate water intake is also needed along with regular toilet training sessions (4).

CONCLUSION

Our case is an unfortunate one in which patient did not survive. Therefore we highly recommend physicians to have a strong index of suspicion for this condition. Early detection and intervention is required to achieve a favorable outcome in these patients.

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