

# A case report of giant fecaloma in a 35 year old woman

## Introduction

Fecaloma is defined as clinical condition in which there is accumulation of faeces in rectum & sigmoid colon, which is harder in consistency in comparison to impacted faeces due to corprostasis, it stagnates in the intestine and remain symptomless until intestine it deforms intestine<sup>(1)</sup>. These are the impacted faeces which can occur due to various pathologies such as Hirschsprung's disease, psychiatric patients, neglected elderly or bedridden patients, Chagas disease, inflammatory and neoplastic conditions<sup>(2)</sup>. We report a case of the giant fecaloma in a 35 year old woman.

## Case presentation

A 35 year old woman reported to our hospital with the one year history of constipation and gradual lower abdomen distension, attendants and caregivers reveal the history of a single bowel movement after every three days. She often developed moderate constipation, for which she used to go to primary care physicians who prescribed her Laxatives due to which she often developed diarrhoea.

Patient had no significant history of blood in stool, pain in abdomen, nausea, vomiting, fever, anorexia, weight loss or any urinary complaints, and overflow diarrhoea.

Examination of the patient reveal normal temperature, blood pressure of 100/70 mm Hg, pulse rate 83/min, Respiratory Rate of 16 breaths/min. General physical examination (GPE) of patient was absolutely normal.

Abdominal inspection revealed an irregularly distended abdomen more so in the left half with no evidence of increased peristalsis. During palpation, multiple hard nodular but mobile lumps were palpable in left lumbar, iliac and umbilical region. There was mild hepatomegaly, bowel sound appeared normal. Direct Rectal examination revealed that the patient had impacted hard faeces present in the rectum which were hard in consistency were notable during the examination. Rest of the systemic examination was unremarkable

Laboratory investigation showed haemoglobin 13.2 g/dl, WBC 8700/mm<sup>3</sup>, platelets 311 lac/mm and ESR was 18 mm in the first hour. The renal functions and serum electrolytes were normal at creatinine of 0.6 mg/dl, serum Na 136 mEq/L, serum K 4.3mEq/L, urinalysis of the patient revealed 3\_4 hPF and liver function tests were normal. Chest radiograph was unremarkable. Ultrasound of the abdomen showed evidence of large calcified mass lesions in the para-umbilical region extending into the pelvis. Contrast enhanced CT abdomen; delayed images revealed dilated rectum as well as sigmoid colon due to loaded fecoliths and extending into the other parts of large bowel (Figure 1). Mass effect was also observed on the urinary bladder and bilateral ureters, but there was no evidence of hydronephrosis.

Patient had moderate pain with the history of use of pain killers; repetitive enemas were done which were unsuccessful. So, we planned rectosigmoidoscopy, which went up to 24 mm, of rectum, where a faecal matter was present, biopsies were not attempted but fragmentation were performed of stool, but later it was stopped because of pain during the procedure.

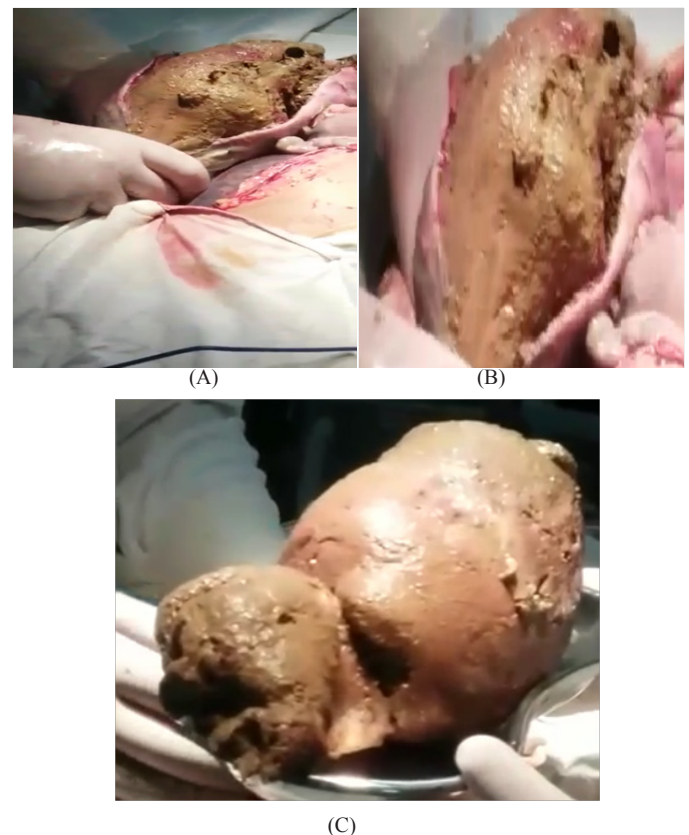
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**Figure 1** Delayed images revealed dilated rectum as well as sigmoid colon.

Due to unsuccessful elective laparotomy, a midline incision of 22 cm was given supra umbilical and infra umbilical, where we found about 6cm size of sigmoid colon was present in the centre of the abdomen. We gave an incision on the anterior surface of the colon, stool masses were evacuated, which were hard in consistency. There were 2 huge fecaloma and few small fecaloma were present, 2cm part of the sigmoid colon were resected and given end to end anastomoses. Microscopic evaluation of the sigmoid colon revealed normal colon wall histology, patient recovered well from laparotomy.

## Discussion

Faecal impaction is characterised by the obstruction in the passage of stool. It may present in the older age, adults as well as children, a

number of cases have been reported to signify the importance of the impacted stool. Article search reveals that a study conducted in the geriatric ward that 42% patients get faecal impaction.<sup>1</sup> It present in the clinics with the overflow type of diarrhoea, constipation, weight loss and vague abdominal discomfort after meals, most common symptom of presentation is constipation.<sup>2</sup>

Giant fecaloma is composed of intestinal debris and faecal mass, it may appear as laminated material with deposition of the calcium, distal colon and sigmoid colon are most common sites of faecal obstruction.<sup>3-6</sup>

In few cases it may complicate into various manifestations like causing an impact on the colonic wall, it may cause Gastrointestinal bleed,<sup>2</sup> intussusception, ureters causing obstruction into urinary flow leading to hydronephrosis<sup>7</sup> but none of the symptom was seen in our case. Our patient was managed also with laxatives initially, previous reported cases were also managed conservatively.<sup>8</sup> Another approach that can also be used is endoscopic evaluation<sup>9</sup> but if these conservative treatments fail to relieve then we treat patient through surgical procedure, we also had to make similar approach for our patient.<sup>4</sup> Surgical procedure involves resection of the perforated colonic segment physicians must keep a close follow up of these patients even after surgery with the diet education as well as the proper toilet trainings.<sup>10</sup>

### Acknowledgments

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### Conflicts of interest

The authors declare no conflicts of interest.

### References

1. Read NW, Celik AF, Katsinelos P. Constipation and incontinence in the elderly. *J Clin Gastroenterol.* 1995;20(1):61–70.
2. Kaufman SA, Karlin H. Fecaloma of the sigmoid flexure. *Dis Colon Rectum.* 1966;9(2):133–136.
3. Rajagopal A, Martin J. Giant Fecaloma with idiopathic sigmoid megacolon: report of a case and review of the literature. *Dis Colon Rectum.* 2002;45(6):833–835.
4. Sonnenberg A, Koch TR. Physicians visits in the United States for constipation: 1958–1986. *Dig Dis Sci.* 1989;34(4):606–611.
5. Mahajna A, Krausz MM. Ileocolic intussusception in an adult patient due to a cecal fecalith. *Isr Med Assoc J.* 2009;11(1):58–59.
6. Arana-Arri E, Cortés H, Cabriada V, Lekerika N, et al. Giant faecaloma causing perforation of the rectum presented as a subcutaneous emphysema, pneumoperitoneum and pneumomediastinum: a case report. *Eur J Emerg Med.* 2007;14(6):351–353.
7. Knobel B, Rosman P, Gewurtz G. Bilateral Hydronephrosis due to fecaloma in an elderly woman. *J Clin Gastroenterol.* 2000;30(3):311–313.
8. Kim KH, Kim YS, Seo GS, et al. A Case of Fecaloma Resulting in the Rectosigmoid Megacolon. *Korean J Gastrointest Motil.* 2007;13(1):81–85.
9. Sakai E, Inokuchi Y, Inamori M, et al. Ileal Fecaloma Presenting with Small Bowel Obstruction. *Pediatr Gastroenterol Hepatol Nutr.* 2015;18(3):193–196.
10. Monica Gupta, Purnima Aggarwal, Ram Singh. A Case of Giant Fecaloma in a 32-Year-Old Woman. *Austin J Clin Case Rep.* 2014;1(4):1017.