

Case Report

Fecaloma mimicking acute abdomen: a diagnostic challenge

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ABSTRACT

Fecaloma can occur as a result of several causes and may present as a challenging diagnostic and therapeutic problem. In this case report, we would like to present the case of a 37-year-old male who presented with abdominal distention and pain. His previous medical history was significant for catatonic disorder due to psychiatric conditions. Physical examination showed a distended abdomen with focal tenderness in the lower quadrant regions. Bowel sounds were decreased and fecal materials were palpable on digital rectal examination. Upon further clinical interrogation, the patient admitted to constipation for the past three months. Except for leukocytosis (28,000/mm³ (normal range 4.5-10.5/mm³) and elevated C reactive protein (304mg/L) levels, all other laboratory findings were normal. Abdominal plain x-ray demonstrated a predominantly feces-filled colon. This was confirmed on abdominal computed tomography (CT) scan as a giant sigmoid colon, measuring 25 cm in diameter and lateralized bladder. The patient was initially treated with oral laxatives and rectal enema, which were ineffective. He was then treated with evacuation of the feces under general anesthesia. After then, patient's symptoms were relieved. Post-operative CT imaging confirmed a decrease in the size of the sigmoid colon to an acceptable measure. No mass or polypoid lesions were seen on colonoscopy. This report attracts the attention how sigmoid colon can be a long-term reservoir for fecal contents without serious symptoms but only abdominal distention. Evacuation of fecal contents under general anesthesia may help to relieve fecaloma without surgery.

Keywords: Acute abdomen, Fecaloma, Treatment approach

INTRODUCTION

Fecaloma is defined as a mass of feces accumulated in the colon. After accumulation of feces for a long time period, it expands and deforms the intestine, even may develop into a large tumor-like mass. Fecalomas, often giant ones, have been described in several conditions such as Hirschsprung's disease, psychiatric patients, bedridden patients, inflammatory and neoplastic conditions, and in patients suffering from idiopathic chronic constipation. Diagnosis and treatment modalities can be various depending on the primary cause and patients overall health condition. We aimed to highlight the diagnostic and therapeutic approach for fecaloma in the emergency unit.

CASE REPORT

A 37-year-old male presented with abdominal distention and pain. His previous medical history was significant for catatonic disorder due to psychiatric conditions for which he took antipsychotic medications. Physical examination showed a distended abdomen with focal tenderness in the lower quadrant regions. Bowel sounds were decreased and fecal materials were palpable on digital rectal examination. Upon further clinical interrogation, the patient admitted to constipation for the past three months. Except for leukocytosis (28,000/mm³ (normal range 4.5-10.5/mm³) and elevated C reactive protein (304mg/L) levels, all other laboratory findings including renal function tests and serum electrolytes were unremarkable.

Abdominal plain x-ray demonstrated a predominantly feces-filled colon segment. This was confirmed on abdominal computed tomography (CT) scan as a giant sigmoid colon, measuring 25 cm in diameter and compressing the bladder laterally (Figure 1A-B).

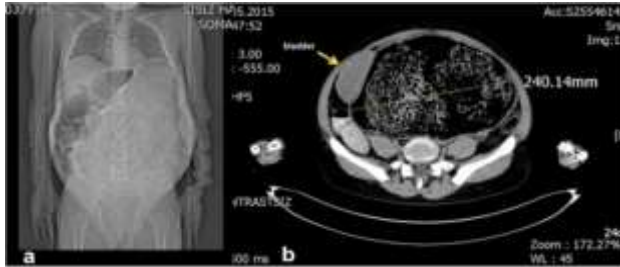


Figure 1: (A-B) Initial computed tomography demonstrating giant sigmoid colon full-filled with feces and displaced bladder, both with an increased wall thickness.



Figure 2: (A-B) Sigmoid colon with a decreased diameter after manual evacuation of the sigmoid colon under general anesthesia.

There were no findings indicating compression of other adjacent organs. The patient was initially treated with oral laxatives and rectal enema, however medical treatment was found to be ineffective due to non-compliance to the treatment. He was then treated with evacuation of the feces under general anesthesia. The patient's symptoms were relieved by post-operative day one. Post-operative CT imaging confirmed a decrease in the size of the sigmoid colon to an acceptable size (Figure 2A-B). No mass or polypoid lesions were seen on colonoscopy.

DISCUSSION

Fecal impaction is an accumulation of feces in the rectum and/or colon, which cannot be evacuated, resulting in a large abdominal mass. This entity can occur as a result of several causes and may present as a challenging diagnostic and therapeutic problem. The primary cause in this case was immobility due to catatonic disorder and antipsychotic drug treatment. Antipsychotic drugs

can lead to constipation through anticholinergic activity that block parasympathetic tone of smooth muscle of the gastrointestinal tract.² Because of chronic course of disease, it presents as diagnostic challenge. In most of the cases, patients develop stercoral ulcers and subsequent perforation may occur. Therefore, resection of dilated colon segments to prevent stercoral perforation is also recommended.³ Interestingly, the walls of the bladder and sigmoid colon in this patient appeared to be thicker than normal on CT imaging due to slow progression. It was plausible factor for giant progression of the fecaloma without any serious complication such as perforation. This also encouraged us to manual evacuation of the feces through the anus since laxatives did not work. Surgical intervention for uncomplicated fecal impaction is rarely needed; however, laparotomy may be indicated if medical therapies are not effective, particularly for fecaloma. However, in selected cases, evacuation under general anesthesia can be a better option with low morbidity.

CONCLUSION

This report draws attention to how the sigmoid colon can be a long-term reservoir for fecal contents resulting in severe abdominal distention mimicking acute abdomen. Diagnostic imaging methods may help to determine treatment approach; surgery or noninvasive evacuation of fecal contents. For non-compliant patients with medical therapy, interventional procedures remain preferential to treat extreme fecal impaction.

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REFERENCES

1. Rajagopal A, Martin J. Giant fecaloma with idiopathic sigmoid megacolon: report of a case and review of the literature. *Dis Colon Rectum*. 2002;45:833-5
2. Tripathi KD. *Essentials of medical pharmacology*. 2008;106-15.
3. Maurer CA, Renzulli P, Mazzucchelli L, Egger B, Seiler CA, Büchler MW. Use of accurate diagnostic criteria may increase incidence of stercoral perforation of the colon. *Dis Colon Rectum*. 2000;43:991-8.

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