

# Giant Fecaloma Causing Large Bowel Obstruction: A Case Report

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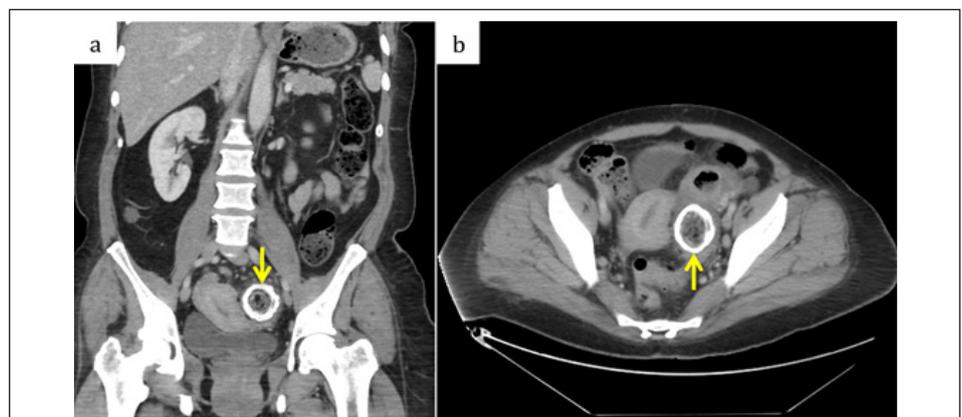
## Abstract

Fecalomas are masses of hardened stool that are typically impacted in the sigmoid colon and rectum. Fecalomas are commonly associated with chronic constipation, Hirschsprung's disease, Chagas disease, and multiple psychiatric conditions. We present a case of a giant fecaloma resulting in complete large bowel obstruction and suggest a five-year abdominal ultrasound monitoring of adults presenting with chronic constipation and/or chronic nonspecific gastrointestinal (GI) complaints.

## Introduction

Fecaloma is an accumulation of hardened impacted stool typically located in the sigmoid colon and rectum [1-3]. The accumulation of fecal matter builds up in the intestine and stagnates, further increasing in size and volume taking on the characteristics of a tumour [4,5]. Symptoms of a fecaloma are commonly nonspecific including chronic constipation, vague abdominal pain after meals, and weight loss [6]. In cases of large fecaloma, patients may feel a palpable hardened mass in their abdomen. Fecalomas have been associated with elderly patients with chronic constipation, psychiatric conditions, Hirschsprung's disease, and Chagas disease [7]. Fecaloma is diagnosed radiologically through x-rays, barium enema, abdominal ultrasound, or abdominal computed tomography (CT) scans [8]. Most cases are managed conservatively with laxatives and enemas. However, some cases are refractory to conservative management [9], as in this case, requiring surgical intervention for removal of the fecaloma preventing further complications. We report a case of a giant fecaloma causing a complete large bowel obstruction requiring surgical management.

## Case Report

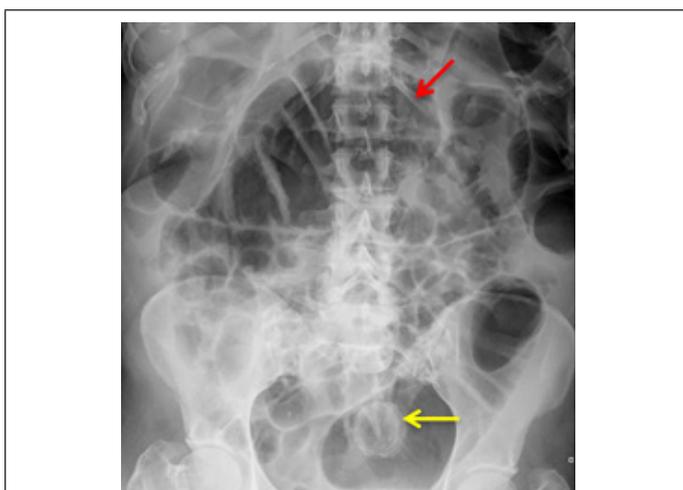


**Figure 1:**

(A) Abdominal computed tomography scan with IV contrast shows thick-rim calcification.

(B) The diameter of the fecaloma is greater than the surrounding colon.

A 46-year-old-female with a history of chronic constipation and abdominoplasty (10+ years ago) presented with a one-month history of worsening abdominal pain, nausea, and vomiting. The patient denied the passage of flatus and stool three days prior to presentation. On physical examination, the patient appeared well with normal vital signs. Abdominal examination was remarkable for distention in the periumbilical area, hypoactive bowel sounds, and diffuse tenderness across the whole abdomen. Hematologic testing, basic metabolic panel, and liver biochemical tests were normal. An abdominal CT scan with intravenous (IV) contrast revealed a densely calcified rim of a fecaloma measuring 4.7 cm in diameter located in the mid sigmoid colon with wall thickening around the mass (Figure 1). The sigmoid collapse was noted at the level of the fecaloma with no fluid collections. At the time of admission, there was a mild bowel obstruction noted. The following day, the patient developed worsening abdominal pain. A two-view x-ray of the abdomen revealed air distended large and small bowel loops indicating complete large bowel obstruction (Figure 2). As a result, the patient underwent an emergency exploratory laparotomy that resulted in partial colon resection with colostomy formation. A giant fecaloma and a small piece of old gauze found in the patient's rectum was retrieved. Post-operative period of the patient was uneventful. The ostomy was deemed a candidate for reversal four months after the exploratory laparotomy.



**Figure 2:** Abdominal X-ray shows fecaloma (yellow arrow) and air distended intestines (red arrow) secondary to complete large bowel obstruction.

## Discussion

Fecaloma is a result of the hardening of feces into lumps of many different sizes that are typically denser than fecal matter in cases of fecal impaction [6]. The most common location of a fecaloma is the distal sigmoid colon. The mass is typically composed of intestinal debris and fecal matter; however, foreign bodies, such as seen in this case, can serve as a nidus for formation [6]. Fecaloma presents variably from urinary retention [10] to toxic megacolon [1,5,11]. Diagnostic confirmation is made through an abdominal CT scan with IV contrast that shows a fecal mass that is greater than or equal to the diameter of the colon or through

colonoscopy [12]. Complications seen in patients with fecaloma include hydronephrosis, nerve compression resulting in sciatica, deep vein thrombosis (DVT), ulceration, bleeding, obstruction, and colon perforation at the site of the fecaloma [6]. Most of the fecal impactions are successfully managed conservatively with bowel rest, laxative, enema, and digital evacuation [13]. As a result, the consulting gastroenterology team in this case had initially recommended a conservative regimen of tap water enemas and polyethylene glycol (PEG) for three days prior to intended colonoscopy with the use of diet coca-cola to aid in dissolving and breaking up the calcified mass. Although this represents an innovative approach to conservative management some have argued against it. Tchanagi et al suggests that surgery should be considered first-line in the treatment of giant fecaloma [14]. In the report, the authors argued that the peritoneal complications of rupture and bowel resection in cases of emergency exploratory laparoscopies for giant fecaloma outweighed the benefits of first-line conservative management.

The impressive rim calcification of the mass as seen on the abdominal CT, indicated that the large fecaloma was present in the patient for many years (Figure 1). The patient's description of her bowel habits was significant for chronic constipation as well as chronic vomiting, likely secondary to fluid accumulation proximal to the fecaloma. Unfortunately, the fecaloma was not identified until this hospitalization. This case demonstrates the need for improved diagnostic workup of nonspecific GI complaints and chronic constipation. As fecaloma is a radiological diagnosis, this report suggests that adults with chronic constipation and chronic nonspecific GI symptoms be screened for fecaloma by routine abdominal ultrasound every five years. Additionally, positive or indeterminate ultrasound results should be followed by an abdominal x-ray. Early suspicion and intervention are required to achieve favourable outcomes in patients with giant fecalomas. This report considers the risks of complications by fecaloma to outweigh the risks and potential harm of abdominal ultrasound or abdominal x-ray in adults with chronic constipation and nonspecific GI complaints. Furthermore, it should be noted that the importance of early surgical intervention should be heavily considered over conservative management, as in the present case.

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