

Case Report

Fecaloma Causing Small Bowel Obstruction without Predisposing Factors

Abeyasinghe AHMGB¹, Wimalasena GADNB² and Herath MTD³

¹Teaching Hospital, Sri Lanka

²Department of Community Medicine, Faculty of Medicine Peradeniya, Sri Lanka

³Department of Physiology, Wayamba University Kuliyaipitiya, Sri Lanka

Abstract

Fecaloma is a mass of accumulated fecal matter. It is usually found in the rectosigmoid area in patient with chronic constipation. They generally present with mechanical obstruction of the colon. This phenomenon is rare in the right side of the colon and small intestine. This reporting patient presented with small bowel obstruction due to fecaloma at the distal ileum.

Keywords: Fecaloma; Intestinal obstruction; Conservative management

Introduction

A fecaloma is a mass of accumulation of feces that is much harder in consistency than the usual fecal impaction. The first reported fecaloma described in 1967 [1,2]. Their accumulation of fecal matter form a mass which is separated from the rest of the bowel content [3,4]. It has been reported in patients with Hirschsprung disease, Diabetic nephropathy, and idiopathic chronic constipation and patient with anti-psychotic treatment [5]. Fecaloma are usually located in the sigmoid colon and rectum but rarely in the cecum [6,7]. Most fecaloma in the colon could be successfully managed by conservative procedures whereas when the conservative management fails surgical intervention may be needed [8]. These patients usually present with features of bowel obstruction. Our patient present to us with features of small bowel obstruction secondary to fecaloma with no identifiable predisposing factors.

Case Presentation

A 45 years old female patient with a history of bronchial asthma on inhaler presented with colicky abdominal pain, bilious vomiting and no bowel motion for the last two days. She had no diabetes mellitus, hypertension or no significant diseases leading to constipation. She had no history of chronic constipation. On examination her vital parameters were within normal limits other than tachycardia. Abdominal examination reveal significantly distended abdomen with no tenderness. Her bowel sounds were hyperactive. The laboratory investigations were normal except high C reactive protein. The routine

abdominal X-ray showed dilated jejunal loops with multiple fluid levels. The ultra sound performed suggested intestinal obstruction (Figures 1 and 2). Due to the fact of small bowel obstruction with tachycardia and no other obvious course for paralytic ileus. It was decided to perform exploratory laparotomy. In the laparotomy it was noted a fixed firm intra luminal mass at the distal ileum (Figure 3). The ileum distal to the mass was collapsed and no other significant intra-abdominal pathology noted. Enterostomy was performed to see the said lump and noticed a yellowish inspissated ball of feces measuring approximately 4 cm in diameter. The specimen was carefully analysed and no significant abnormalities found other than the fecal matters. The Enterostomy was closed. Routine abdominal closure done and patient was sent to ward to follow routine post laparotomy procedures (Figure 4).

Discussion

Fecal impaction is common among elderly population whereas fecaloma is a relatively rare condition [9]. Fecaloma has been described



Figure 1: Erect abdominal X-ray.

Citation: Abeyasinghe A, Wimalasena G, Herath M. Fecaloma Causing Small Bowel Obstruction without Predisposing Factors. *Ann Clin Case Stud.* 2022; 4(1): 1049.

Copyright: © 2022 Abeyasinghe AHMGB

Publisher Name: Medtext Publications LLC

Manuscript compiled: Feb 24th, 2022

***Corresponding author:** Abeyasinghe AHMGB, Consultant Surgeon, Teaching Hospital, Kuliyaipitiya, Sri Lanka, Tel: +94-718061353; E-mail: gbabey@sltnet.lk



Figure 2: Supine abdominal X-ray.



Figure 1: Erect abdominal X-ray.



Figure 4: Feecal ball (after removing).

the lumen get fully occupied leading to mechanical obstruction [10]. It is more commonly seen in the patient with diseases leading to chronic constipation. Higher number of incidence seen mostly in the left colon compared to the right colon. It is explained by the fact that stool in the left colon being firm than the right colon while the diameter in the left side is narrower [8,10]. The small bowel is quite an unusual sight [6]. The symptoms of fecaloma are usually nonspecific which include chronic constipation, “overflow type diarrhea”, and vague abdominal discomfort etc [11]. Preoperative diagnosis could be made when the characteristic intraluminal mass is noted in the CT scan [6]. Generally in our setup we do not have easy access to CT scanner for this type of patient.

If it were to happen in the colon, conservative measures would supersede the surgical intervention such as nasogastric tube, hydration, laxative and enema, even digital evacuation. But once it happens in the small intestine success rate of conservative management is minimum. In our patient fecaloma develop in the distal ileum leading to mechanical obstruction of small intestine where we could not find underline pathology. As it was small bowel obstruction and preoperative pathology could not identify, we embark on operatory measures.

Conclusion

Fecaloma in the small intestine is very rare but it should be in the list of differential diagnosis when patient present with mechanical obstruction of small intestine especially in a chronic constipate patient. Once patient is managed successfully it is important to emphasis on proper dilatory habit including high fiber diet, adequate water and fruits to soften the stool. In children the toilet training is utmost important.

References

- Mushtaq M, Shah MA, Malik AA, Wani KA, Thakur N, Parry N. Giant fecaloma causing small bowel obstruction: case report and review of the literature. *Bull Emerg Trauma* 2015;3(2):70-2.
- Abella ME, Fernandez AT. Large fecaloma. *J Dis Colon Rectum*. 1967;10(5):401-4.
- Rajagopal A, Martin J. Giant Fecaloma with Idiopathic Sigmoid Megacolon: report of a case and review of the literature. *J Dis Colon Rectum*. 2002;45(6):833-5.
- Garisto JD, Campillo L, Edwards E, Harbour M, Ermocilla R. Giant fecaloma in a 12 years old boy: a case report. *Cases J*. 2009;2(1):127.
- Kim SM, Ryu KH, Kim YS, Lee TH, Im EH, Huh KC, et al. Cecal fecaloma due to intestinal tuberculosis: endoscopic treatment. *Clin Endosc*. 2012;45(2):174-6.
- Cid AA, Pieturk T, Bidari Cz, Ehrinpreis MN. Cecal fecaloma mimicking colonic neoplasm. *Dig Dis Sci*. 1981;26(12):1134-7.
- Gilbert RF. Cecal infarction secondary to a distal obstructing fecaloma: association with drug abuse. *South Med J*. 1980;73(9):1296-7.
- Sakai E, Inokuchi Y, Inamori M, Uchiyama T, Takahashi H, et al. Rectal fecaloma: successful treatment using endoscopic removal. *Digestion*. 2007;75(4):198.
- Yoo HY, Park HW, Chang SH, Bae SH. Ileal fecaloma presenting with small bowel obstruction. *Pediatr Gastroenterol Hepatol Nutr*. 2015;18(3):193-6.
- Yucel AF, Akdogan RA, Gucer H. A giant abdominal mass: fecaloma. *Clin Gastroenterol Hepatol*. 2012;10(2):e9-e10.
- Gupta M, Aggrawal P, Singh R, Lehl SS. A case of giant fecaloma in a 32 years old women. *Austin J Chin case Rep*. 2014;1(4):2.

in the literature for a long time [1,8]. In the process of formation of fecaloma there will be an accumulation of fecal matter within the intestinal lumen which then stagnate and increase the volume until