Case Report

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Giant Fecaloma Causing Small Bowel Obstruction: Case Report and Review of the Literature

***Mosin Mushtaq*, Mubashir A Shah, Aijaz A Malik, Khurshid A Wani, Natasha Thakur, Fazl Q Parray**

Department of General and Minimal Access Surgery, Sher-I-Kashmir Institute of Medical Sciences (SKIMS), Srinagar, J & K, India

***Corresponding author:** *Mosin Mushtaq*
Address: Department of General and Minimal Access Surgery, Sher-I-Kashmir Institute of Medical Sciences (SKIMS), Srinagar, J & K, India. **Tel:** +91-9419040388
e-mail: mozn33@gmail.com

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ABSTRACT

Fecaloma is a mass of hardened feces being impacted mostly in rectum and sigmoid. The most common sites of the fecaloma is the sigmoid colon and the rectum. There are several causes of fecaloma and have been described in association with Hirschsprung's disease, psychiatric patients, Chagas disease, both inflammatory and neoplastic, and in patients suffering with chronic constipation. Up to now several cases of giant fecaloma has been reported in the literature most of them presenting with megacolon or urinary retention. We herein report a case of giant fecaloma leading to bowel obstruction who was successfully treated by surgery. A 30-yrar-old man presented with sign and symptoms of acute bowel obstruction. He underwent exploratory laparotomy and enterotomy. He was found to have a giant fecaloma causing bowel obstruction in the jejunum. He was discharged after the operation with good condition. Jejunal fecaloma is extremely rare condition.

Keywords: Fecaloma; Bowel obstruction; Jejunum; Enterotomy.

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Introduction

Fecaloma was first described in 1967 [1] being a mass of hardened feces being impacted mostly in rectum and sigmoid [2-4]. The consistency of the fecaloma is more than fecal impaction due to coprostasis [3]. Usually, the fecal matter accumulates in the intestine, then stagnates and increases in volume until the intestine becomes deformed and acquires characteristics similar to those of a tumour [5,6]. There are several causes of fecaloma and have been described in association with Hirschsprung's disease [4], psychiatric patients, Chagas disease, both inflammatory and neoplastic, and in patients suffering with chronic constipation [7]. Up to now several cases of giant fecaloma has been reported in the literature most of them presenting with megacolon [2,7,8] or urinary retention [9]. We herein report a case of giant fecaloma leading to bowel obstruction that was successfully treated by surgery.

Case Report

A30-year-old man referred to our emergency room

with abdominal pain, vomiting and abdominal distention since 3 days prior to presentation. The patient had undergone laparotomy for duodenal ulcer perforation about 10 years before. On physical examination, the patient was febrile (temperature was 39.1˚C orally), had a pulse rate of 90/minute, blood pressure of130/70 mmHg and normal respiration. Abdominal examination revealed distention in periumbilical area with diffuse tenderness over whole abdomen. Plain standing abdominal radiography revealed multiple air-fluid levels. In view of previous abdominal scar and clinical and radiological features of obstruction, a diagnosis of adhesion obstruction was made. After proper resuscitation, patient was planned for exploratory laparotomy. On operation small gut was distended up to mid jejunum with an intraluminal mass obstructing the mid jejunum. Below that lesion small gut was collapsed. Enterotomy was made just below the site of obstruction in the normal gut and againt fecaloma was retrieved (Figure 1). Then the enterotomy was closed with poly-galactinsuture. Post-operative period of patient was uneventful. He was discharged from the hospital with good condition and was healthy in 1-month follow up.

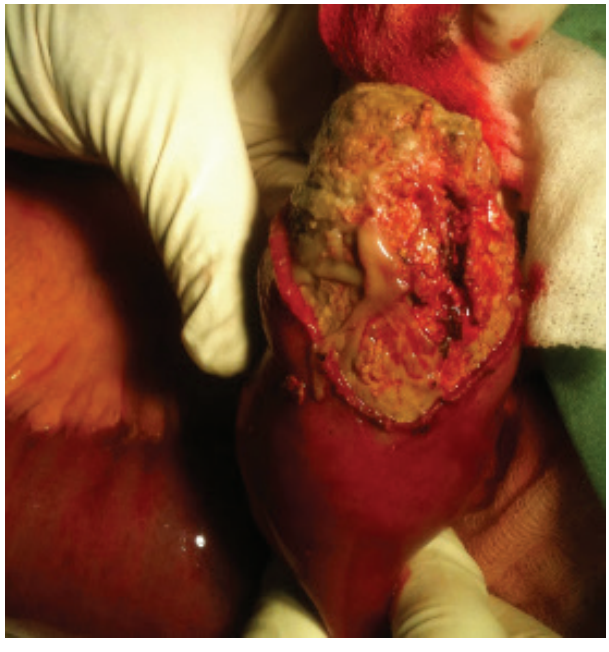

Fig. 1. Giant fecaloma in small bowel leading to obstruction being treated by laparotomy.

Discussion

Accumulation of hard fecal matter with in the bowell umenthatis separable from rest of bowel contents is referred to fecaloma [10,11]. Fecaloma is most common on left side of colon because stool becomes firmer and colon diameter is small as compared to right. The cecumis unusual site with very few cases reported in English literature [2,6-8,12,13]. Fecaloma presents variably from urinary retention [9] to toxic megacolon [2,7,8] or abdominal mass [3,5]. However bowel obstruction has not been reported as the cause of the bowel obstruction in the literature. Previously it has been reported that the none of the patients in a large series of 411 patients with bowel obstruction were found to have fecaloma [14].

There are multiple causes of fecaloma formation but in our case the cause was not evident as there was no history of altered bowel habits. Also fecaloma was present in jejunum were stools are mostly in liquid consistency. This is one of the very few cases of small gut fecaloma reported in literature. We analysed the specimen to rule out any nidus of bezoar over which this fecaloma had formed, but there was no evidence of be zoarandit was only fecal matter. The composition of the fecaloma has been found to be mostly the fecal matter and debris [10]. The fecaloma is mostly formed in a laminar fashion with layers of classification between the feces [15]. The management is also controversial. Most of the fecal impactions are successfully managed conservatively with bowel rest, laxative, enema and digital evacuation [16]. Most of the reported cases have undergone laparotomy and surgical removal of the fecaloma [2,5,7,8,12,13]. Endoscopic removal of the fecaloma has also been reported in the literature [11]. When conservative measures have failed, as in this case, a surgical intervention may be needed for removal of a fecaloma and preventing the further complications [9,11,12,16].The outcome is mostly favourable after both conservative and surgical management. However in elderly and those with intestinal rupture the outcome is poor [7,15]. The surgical interventions are also various based on the location and the symptoms of the patients. In the current case the fecaloma was found in the jejunum leading to bowel obstruction. The condition was successfully treated by exploratory laparotomy and enterotomy. The outcome was favourable.

In conclusion, early suspicion and intervention is required to achieve a favourable outcome in patients with bowel obstruction. The jejunal fecaloma is extremely rare and to the best of our knowledge this is the first reported case in the English literature.

Conflict of interest: None declared.

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