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Giant Fecaloma Causing Intestinal Obstruction and Urinary Retention: Rare Case Report

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Abstract **Case Report**

Fecaloma is a mass of hardened feces impacted mostly in left colon and rectum. Several causes of fecalomas have been described in literature, of which chronic constipation. It is a common pathology in elderly patients. The non-specific clinical signs, harmless, sometimes misleading, are at the origin of long evolutions which can lead to real life-threatening situations [1]. We herein report the case of a 61-year-old patient who presents a giant fecaloma located in the sigmoid colon and rectum, associated to urinary retention.

Keywords: Giant fecaloma, Bowel obstruction, urinary retention.

INTRODUCTION

Fecaloma is defined as a mass of hardened feces being impacted mostly in colon sigmoid and rectum [2-3]. It can occur due to various pathologies including chronic constipation which constitutes a major health problem. Most patients with this condition can be treated through primary care network; however, some patients with chronic constipation may present a more severe form such as fecal impaction complicated by megacolon. Although rare, fecal impaction can even affect nearby organs.

We report the case of a 67 years old patient, who presented to the emergency service for a giant fecaloma complicated by a urinary retention, following a progressing constipation for about 4 months.

CASE REPORT

A 61-year-old man consults in the emergency room of our hospital for chronic constipation associated to a progressive abdominal distension evolving for about 4 months, complicated 3 days prior to presentation, with abdominal pain, nausea and a urinary retention for more than 24 hours. The patient had no medical history, hospitalization or any prior surgery. Clinical examination found a conscious patient; vital signs were within normal limits: normal body temperature at 37.2°C, a pulse rate of 96 beats/minute, blood pressure of 110/ 60 mmHg and normal respiration. Abdominal examination found a very large abdominal distention affecting all the abdominal quadrants (Figure 2 A), with presence, on palpation, of a large painless and hard mass occupying the left half of the abdomen. Percussion revealed dullness of the right half of the abdomen with tympanism in the rest of the abdomen especially in the right hypochondrium. Direct rectal examination revealed the presence of very hard faeces in the rectum.

Laboratory tests revealed hemoglobin at 13 g / dl, white blood cells at 13 800 elements / ml, urea at 0.6 mg / l, creatinine level at 11 g / l, serum sodium at 133 meq / l and a potassium level of 4.8 meq / l.

The abdomino-pelvic scanner with injection of the contrast product (Figure 1) revealed the presence of a very important rectosigmoid distension reaching 142 mm at the sigmoid level, containing a large fecal impaction surmounted by an intraluminal gas crescent, without sign of digestive distress. It is responsible for a compression of splenic vein which is still permeable and significant bilateral uretero-pyelocaliceal dilation upstream of a large bladder globe.

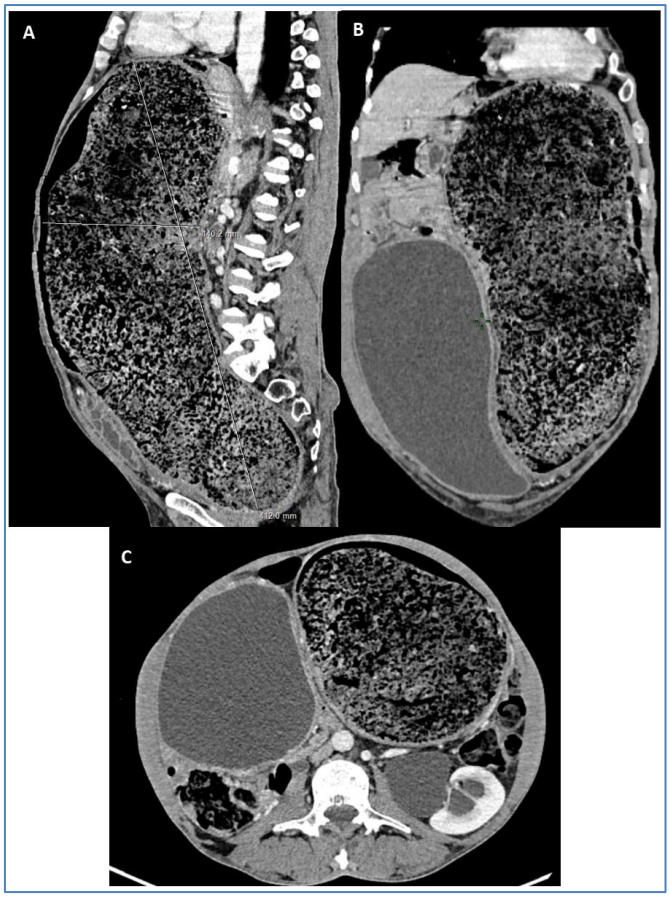

Fig-1: Abdominal CT after injection of contrast product: Sagittal (A) coronal (B) and axial (C) slice: Significant recto-sigmoid distension with fecal content in favor of a large fecaloma associated with a large bladder ball by compression

Repeated enemas and laxatives, including polyethylene glycol (PEG) failed to evacuate the fecal mass. Endoscopic fragmentation was also attempted initially, but abandoned due to pain and fear of possible stercoral perforation.

After conditioning, with in particular, correction of hydro electrolytes disturbances and bladder probing (evacuating aproximatively 2 liters of urine). The patient was admitted to the operating room: under spinal anesthesia, in lithotomy position, we realized a digital and instrumental fragmentation of the giant fecaloma with the help of paraffin oil and highly diluted oxygenated serum enemas, thus allowing a progressive evacuation of the fecal impaction (Figure 2 b). The evolution was favorable and marked by the resumption of the intestinal transit. The patient was discharged from the hospital on day 2 under dietary measures and laxatives and referred to the gastroenterology service for aetiologic assessment and further support.

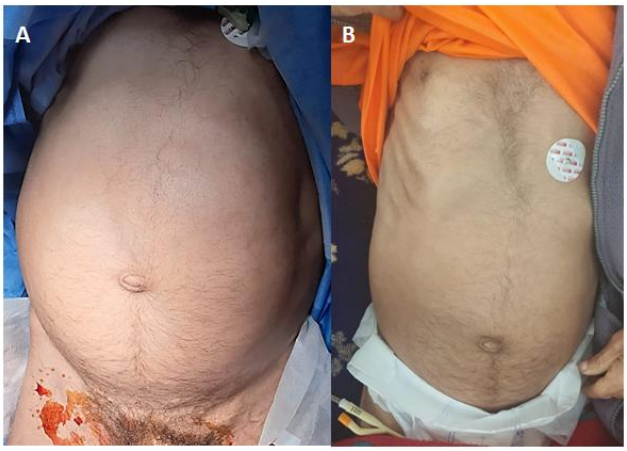

Fig-2: Images of the abdomen before (A) and after (B) the evacuation of the giant fecal impaction

DISCUSSION

Fecaloma was first described by Abella ME and al in 1967 [4] as a mass of hardened feces being impacted mostly in the sigmoid and rectum [2, 3]. The consistency of the fecaloma is harder than the fecal impaction due to coprostasis [5]. Several causes of fecaloma have been described in literature: in association with Hirschsprung's disease [3], psychiatric patients, Chagas disease, inflammatory and neoplastic diseases and in patients suffering with chronic constipation [6], which was the case for our patient who suffered from a chronic constipation evolving for about 4 months. Fecal impaction represents the extreme course of terminal constipation. It is common in the elderly (35% of long-stay hospitalized patients have at least one fecal episode during their hospitalization).

Fecalomas occur generally on the left side of colon because stool becomes firmer and colon diameter smaller as compared to right one [2, 3, 7]. They can manifest in various forms: from abdominal mass [5, 8], or urinary retention [9] to toxic megacolon [2, 6, 10] or even as bowel obstruction [11].

Usually evoked in front of a table of old constipation, it's necessary to know how to pose the diagnosis in front of misleading signs. Hypersecretion of the rectal mucosa, due to the irritation created by the accumulation of dehydrated material can induce false diarrhea [12].

A large fecal impaction can be the cause of a pseudo-tumor syndrome (grinding, tenesmus and false needs) or even signs of compression with edema of the lower limbs [13], sciatica and hydronephrosis secondary to compression of the ureter [14].

Recto-sigmoidoscopy, barium enema and abdominal tomography play an important role in the differential diagnosis. Usually, fecal impaction is treated with conservative methods such as laxatives, enemas and digital evacuation. However, when conservative measures fail, surgery may be necessary to preventing further complications [9, 15, 16-18].

The outcome is generally favorable after both conservative and surgical approach. However, in elderly and patients presenting intestinal rupture, the outcome is poor [6, 19].

CONCLUSION

Constipation is a common problem that can cause fecal impaction and even development of a fecaloma. Fecalomas occur frequently in the left colon and rectum. They can manifest in various ways including bowel obstruction, urinary retention and toxic megacolon. Often treated conservatively with laxatives, enemas and/or digital evacuation. However, when these methods fail, surgical intervention is required to prevent bowel perforation.

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