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An Un usual Case of Large Bowel Obstruction due to Well Formed Fecal Matter: A Case Report

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Dr. Parveen Kumar
Junior Resident-IIIrd Year, Department of Surgery, S.N. Medical College, Agra, U.P.

Dr. J.P.S. Shakya
Associate Professor, Department of Surgery, S.N. Medical College, Agra, U.P.

Dr. Avnish Saxena
Associate Professor, Department of Surgery, S.N. Medical College, Agra, U.P.

Dr. Nitin Goyal
Junior Resident-IIIrd Year, Department of Surgery, S.N. Medical College, Agra, U.P.

ABSTRACT *Fecal impaction is a common gastrointestinal disorder and a source of significant patient suffering with potential for major morbidity.[1] The incidence of fecal impaction increases with age and dramatically impairs the quality of life in the elderly.[2] Large bowel obstruction can be due to multiple causes but here we present a case of large bowel obstruction due to well formed fecal matter.*

Introduction:
Fecal impaction is a disorder characterized by a large mass of compacted feces in the rectum and/or colon, which cannot be evacuated. It may occur in any age, more so in childhood and old age. The etiological factors may be mechanical obstruction, metabolic and endocrine disorders, medications, neurologic and myopathic disorders and functional constipation should be considered.[3] Fecal impaction may present with varied clinical presentation depending on the extent, presence of comorbidities and associated spinal injury or immobility. For patients with fecal impactions, the aims of management are to relieve symptoms, clear out colon, and restore normal bowel habit. Although most impactions occur in the rectal vault, the absence of palpable stool does not rule out a fecal impaction.[4] The most important regimen is to evacuate feces out of colon as soon as possible.[5]

Report of an Unusual Case With Severe Fecal Impaction Responding to Medication Therapy
Case report:
A 22 year old male presented to our emergency department with complains of fever, pain abdomen, dull aching type with decreased appetite since 4 days and not passing flatus and feces since 3 days. Fever subsided on local medication. On examination, patient was moderately build and nourished, no pallor or icterus was present. There was no history suggestive of tuberculosis in family, neither any chronic illness nor long term medication. No history of altered bowel habits or constipation was present. Per abdomen examination revealed mild distension with smiling umbilicus, no organomegaly, tenderness, guarding or rigidity. Bowel sound was absent. DRE was normal. X- Ray abdomen AP Erect view revealed dilated large bowel shadow on right side, with haustrations, no gas under diaphragm or air fluid levels(Fig. 1). USG abdomen showed mild ascites with few dilated bowel loops and mesenteric lymphadenopathy. Laboratory work up not remarkable with normal serum electrolytes except for raised ESR 38 mm and mantoux was negative. Patient was managed conservatively with i.v. fluids and daily PR stimulation of posterior rectal wall for 2 minutes. Due to financial constrains, CECT abdomen could not be done and patient had no signs of improvement after 6 days of conservative management. Patient was planned for exploratory laparotomy and revealed collapsed small bowel and large bowel was mostly filled with well formed feces from caecum till descending colon and a fecolith in sigmoid and appendicular fecolith. Milking of large bowel was done and fecal matter was guided into rectum and removed per anally.

Fig.1. X-Ray Abdomen AP erect view showing large bowel obstruction.

In post operative period, patient was orally allowed on POD 4, after bowel sound was present. After 2 days, patient complained of abdominal distension and on DRE, fecolith was removed. Patient had 2 similar episodes and had significant weight loss in post operative period. On clinical suspicion of hypothyroidism (although no history of thyroid symptoms was given), thyroid profile was sent and revealed low T3 and T4 levels with markedly raised TSH. Tab thyroxine 50 ug was started and patient showed symptomatic improvement and was satisfactorily discharged. He was stable on follow-ups after six weeks.

Discussion:
Fecal impaction can occur in any age group Fecal impaction can lead to serious situations like stercoral ulcer, lower gastro intestinal bleeding, intussusception or even perforation. Main aim of management is to evacuate the feces out of colon and to restore normal bowel habits. Osmotic laxative can be given if there is no evidence of bowel obstruction. Pulsed irrigation is equally effective. Patients who failed to respond to medication need operation. In our case patient had multiple fecal impactions on the right side of the colon and also the patients failed to respond well to conservative management . Food and water intake was ceased. Parenteral nutrition was started. Operative treatment was done when

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conservative management failed.

Once impaction is relieved, it is required to give maintenance therapy to avoid recurrence.

Conclusion:
Fecal impaction is a common gastrointestinal problem. Prompt identification and treatment minimize patient's discomfort and potential morbidity. It is empirical to keep in mind the rare causes of large bowel obstruction in mind, to prevent delay in management of same. Following treatment possible etiologies should be found and preventive therapy instituted to avoid recurrence.

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