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Unusual Cause of Palpable Mass per Abdomen in an Elderly Woman: Fecaloma.

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ABSTRACT

Chronic constipation and fecal impaction are common problems in elderly patient. Drugs causing constipation can add on to it and rarely lead to fecalomas causing abdominal distention, which mimics an abdominal tumor. We present an unusual case of a 63yr old patient under psychiatric treatment for 15yrs ,who developed fecaloma and was managed conservatively. Diagnosis of fecaloma must be considered in elderly patient with history of constipation and mass per abdomen.

Keywords: constipation, fecaloma, abdomen.

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INTRODUCTION

Constipation is a most common GI symptom in elderly which is usually overlooked. Chronic constipation lead to fecaloma very rarely. Fecaloma is organised form of impacted feces, which are much harder in consistency and inability to evacuate. They are most frequently noted in the rectum and sigmoid colon. Usually fecal matter accumulate in the intestine and increases in volume later deforms and acquire characteristics similar to abdominal tumor[1]. There are several causes of fecalomas, seen in association with hirschsprungs disease[2], psychiatric patients, elderly with chronic constipation[3], Chagas disease and prolonged immobilisation. There are several drugs that causes constipation which later can lead to fecal impaction like anti-depressants, anti-psychotics, NSAIDS, opioid analgesics[4] etc

Case Presentation

63yr old postmenopausal woman was admitted to our department with complaints of progressive abdominal distention for 3months, abdominal pain since one week and swelling of left lower limb for 3days. It was associated with loss of appetite and post meal discomfort. She gives history of constipation (1 bowel movement every 2to 3days). She is a parous lady, attained menopause 15yrs back. There was no history of postmenopausal bleeding or discharge PV. There was no history of nausea, vomiting or blood in stools. There was no history of fever, cough, chest pain or any contact with tuberculosis. She is a known case of psychiatric illness on medication since 15 yrs. She is hypertensive and has external hemorrhoids also. She has no history of abdominal surgeries in the past. She has no family history of gynecological and colon cancers.

Examination reveals a normal temperature, supine blood pressure of 140/90mm Hg, pulse rate of 86/min, a respiratory rate of 14 breaths/minute. She weighed 53kg with good overall nourishment. There is a pitting edema in left lower limb upto knee joint. Breast and thyroid were clinically normal, there is no lymphadenopathy. Cardiac and lung examination was unremarkable. Abdominal inspection revealed an irregularly distended abdomen more towards left half with dilated veins over it. During palpation, multiple hard nodular ill-defined mass of varying size arising from pelvis extending up to the umbilicus. Mass was non tender and there was no free fluid. There was no hepatosplenomegaly. Bowel sounds appeared normal. The patient was then referred to the department of obstetrics and gynecology and gynecological speculum examination showed a healthy cervix and Pap smear was taken. On pervaginal examination, vaginal wall was pushed down by a hard mass. On per rectal examination, same hard mass was felt and rectal mucosa was free.

Initial laboratory investigations revealed a hemoglobin 10.1g/dl, WBC 7000/mm³, platelets 2.3lakhs/mm, and ESR 20mm in the first hour. Thyroid function tests and blood sugars were normal. The tumor markers were CA-125-7.7u/ml, CEA-5.3ng/ml, LDH-241, betaHCG-9.7miu/ml, AFP-1.9ng/ml (all normal). The urine analysis, liver function test, renal function test and electrolytes were normal. Contrast enhanced CT abdomen showed gross dilatation of rectum and distal sigmoid colon with ill-defined mass and obstructive features in distal colon.

Figure 1: Sagittal image of CECT abdomen showing massively dilated large bowel loaded with fecalomas



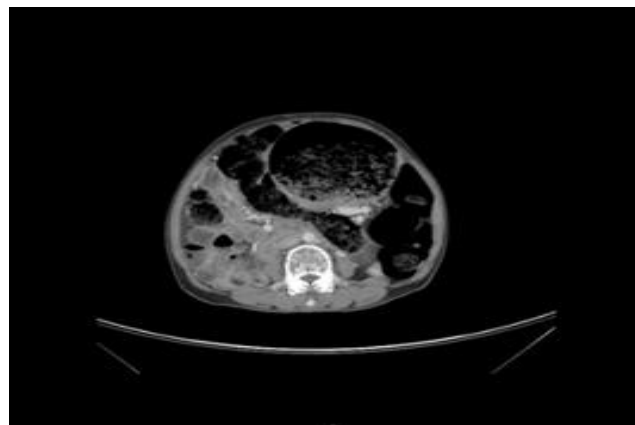
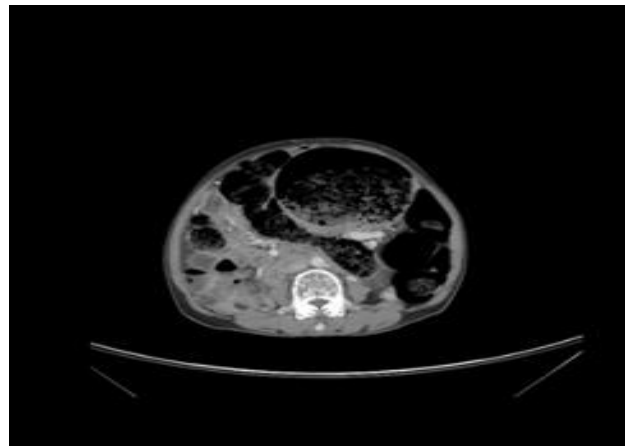
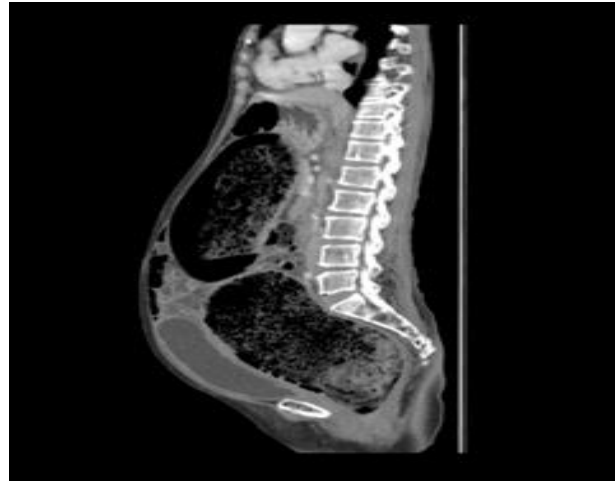


Figure 2: Axial section of CECT abdomen showing massively dilated rectum with giant fecaloma.

Figure 3: Showing normal colonoscopy findings



Urinary bladder was compressed and displaced anteriorly and there was bilateral mild hydronephrosis due to mass effect. Surgery consultation was sought and diagnosis of impacted stools was made. Manual evacuation of hard stool was tried but failed. So after explaining the possibility of stercoral perforation to the patient, she was administered repeated enemas. She passed 10 to 12 episodes of stools following enema. Abdominal mass reduced in size. Colonoscopy was done after adequate bowel preparation which was normal (figure 3). Transvaginal sonography done showed normal study. She was discharged with advice to have high fiber diet and stool softeners was given. Patient was on regular follow up since 5 months and she had no problems.

DISCUSSION

In our patient based on initial history and clinical examination, we suspected ovarian mass but per-rectal examination and contrast enhanced CT of abdomen revealed presence of fecaloma. History of constipation and prolonged drug intake (Olanzapine), which can cause constipation was missed initially. Only few cases of fecaloma in patients with prolonged duration of medication is reported in literature. Most of them are admitted with complications of fecaloma [4,5]. Drugs associate with fecaloma are anti-psychotics, NSAIDS, opioid analgesics [4,6]. Treatment history is important, which can lead to early diagnosis in such cases. Fecaloma should be considered as a differential diagnosis of mass per abdomen in elderly age group [7].

Fecaloma mimics abdominal tumour by causing local complications by compressing the ureters , urinary bladder, uterus, vagina etc. Symptoms of fecaloma are usually nonspecific with overflow type of diarrhea, constipation, unexplained anemia, weight loss and vague abdominal discomfort after meals. Our patient had chronic constipation and post meal-abdominal discomfort. Our patient had fecaloma in the rectum and sigmoid colon with mild hydroureteronephrosis [3]. Timely diagnosis and treatment of fecalomas prevent the life threatening complications like intestinal obstruction [8], stercoral perforation[4], anuria, peritonitis and septicemia. Most of the cases of fecalomas are successfully treated with conservative methods [1] like manual disimpaction of hard stools, laxatives, suppositories and trans-rectal enemas. Surgical interventions are rarely required for uncomplicated fecalomas [9]. When conservative measures fail or when potentially serious complications occur, surgical intervention is needed. Regular follow up of patient is required to prevent recurrence; dietary modification like high fiber diet, prescribing stool softeners, involvement of patient in regular toilet training can increase success rates.

CONCLUSION

Fecaloma are rare but should be considered as differential diagnosis of mass per abdomen in elderly patient with history of constipation, especially on prolonged medication which can cause constipation. Treatment history is essential in making diagnosis. Timely detection and treatment prevents complications of fecalomas.

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