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(CASE REPORT)

Acute small bowel obstruction due to ileal fecaloma in an elderly patient: A Case Report

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Abstract

Acute intestinal obstruction is a surgical emergency whose etiologies vary according to age and comorbidities. Small bowel fecaloma is an exceptional cause. We report the case of an 84-year-old patient with type 2 diabetes mellitus admitted for occlusive syndrome. Surgical exploration revealed an ileal fecaloma responsible for the obstruction. Management consisted of manual disimpaction without enterotomy, with favorable outcome. This case highlights the rarity of this etiology and raises the question of the appropriate timing for surgical intervention in case of failure of the Gastrografin protocol.

Keywords: Small Bowel Obstruction; Fecaloma; Gastrographic; Surgical Emergency

1. Introduction

Acute intestinal obstruction remains a common reason for admission to digestive surgery. Its causes differ worldwide and according to age groups: postoperative adhesions, hernias, tumors, and volvulus are the most frequent. Fecaloma, defined as a hard and compact accumulation of desiccated fecal material, usually occurs in the colon, particularly in the rectosigmoid segment. Its occurrence in the small bowel is exceptional and rarely reported. We present a case of ileal fecaloma causing small bowel obstruction in an elderly patient, and we discuss diagnostic and therapeutic aspects, especially the role of Gastrografin and the optimal timing of surgery.

2. Case Presentation

An 84-year-old male, with a medical history of type 2 diabetes mellitus managed with oral antidiabetic agents, was admitted to the emergency department for occlusive syndrome evolving for 48 hours, presenting with vomiting, cessation of stool and flatus, and progressive abdominal distension.

On admission, the patient was conscious, hemodynamically and respiratorily stable with blood pressure 120/65 mmHg, and afebrile at 36.5°C. Abdominal examination revealed a distended abdomen without surgical scars, diffusely tympanic on percussion, with diffuse tenderness but no guarding or rigidity. Digital rectal examination showed an empty rectal ampulla.

Plain abdominal radiograph revealed multiple small bowel air-fluid levels. Laboratory findings showed mild hypokalemia (3.2 mmol/L), normal sodium, white blood cells 8000/mm^3, hemoglobin 12.8 g/dL, negative CRP, and preserved renal function.

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Abdominal CT scan confirmed a small bowel obstruction with ileal caliber disparity in the left iliac fossa, without suspicious lesion or signs of ischemia.

Initial management included nasogastric tube placement, urinary catheterization, fluid resuscitation, electrolyte correction, and initiation of a Gastrografin protocol under surgical supervision.

After 24 hours, there was no passage of stool or flatus, with worsening electrolyte imbalance and onset of tachycardia at 128 bpm associated with sweating, prompting surgical intervention.

3. Surgical Management

Under general anesthesia, with the patient in supine position, a midline laparotomy was performed. Exploration revealed marked small bowel distension with a caliber discrepancy 70 cm proximal to the ileocecal valve, upstream of a hard intraluminal mass measuring approximately 5 cm, consistent with an ileal fecaloma. Gentle manipulation allowed fragmentation and progression of the mass into the cecum without need for enterotomy. Small bowel decompression was performed. The rest of the abdominal exploration was unremarkable.

The postoperative course was uneventful, with return of bowel function and discharge on postoperative day 3.

Figure 1 Intraoperative view of an intraluminal small bowel fecaloma

Figure 2 Intraoperative image showing small bowel caliber disparity

4. Discussion

Faecaloma is defined as an abnormal, hard, and compact accumulation of dehydrated fecal material, forming a firm intraluminal mass, sometimes stone-like. Its usual location is the rectosigmoid colon, where stool physiologically becomes harder. Small bowel localization is exceptional and rarely reported in the medical literature, most of the reported cases being colonic; which makes this clinical case particularly original.

Several factors may contribute to its formation: intestinal stasis, metabolic disorders (diabetes, hypothyroidism), dehydration, and certain medications such as anticholinergics or opioids. In the small bowel, the most accepted hypothesis is the initial formation of a stercoral plug that migrates and becomes impacted in an ileal segment.

Small bowel obstruction caused by fecaloma presents with the same clinical picture as any other mechanical obstruction: abdominal pain, vomiting, cessation of stool and flatus, and abdominal distension. However, some elements may help in the diagnostic orientation, such as the absence of surgical history suggesting adhesions, and above all the intraoperative finding of a firm intraluminal mass. Imaging plays a central role in the evaluation of this pathology. Plain abdominal radiography is not very specific, showing only air-fluid levels. On the other hand, abdominopelvic CT scan is the key examination, as it may demonstrate a heterogeneous intraluminal mass, sometimes calcified, with proximal dilatation and distal collapse. MRI, although rarely used in an emergency context, may in some cases help to better characterize the stercoral nature of the mass.

In terms of management, initial measures include resuscitation, nasogastric decompression, correction of hydro-electrolyte disorders, and the use of Gastrografin. In case of failure, surgical treatment is required, consisting of manual disimpaction (fragmentation and propulsion toward the cecum), enterotomy if the fecaloma is large or impacted, or even intestinal resection if ischemia or perforation is present.

In our case, advanced age and diabetes probably contributed to stasis and stool dehydration. Therefore, we initiated a Gastrografin protocol, which is often used for both diagnostic and therapeutic purposes in adhesive or functional small bowel obstruction. Its effect usually appears within 12 to 24 hours. In case of lack of improvement and especially clinical deterioration, surgical indication should not be delayed. Our patient illustrates the importance of not prolonging the waiting period beyond 24 hours in order to avoid complications such as ischemia or perforation.

Based on the literature, the few reported cases underline the role of age, diabetes, and polypharmacy. The diagnosis is often mistaken for a bezoar or a tumor. Manual disimpaction is sufficient in the majority of accessible cases.

5. Conclusion

Small bowel fecaloma is a rare cause of intestinal obstruction, to be considered when facing a firm intraluminal obstruction without evidence of tumor. Gastrografin may be used as a diagnostic and therapeutic tool, but failure to improve within 24 hours requires surgical intervention. Manual disimpaction is the treatment of choice, avoiding unnecessary enterotomy, with favorable postoperative outcomes.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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