



CASE STUDY

Stercoral Colitis: Case Study Report

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Introduction

Stercoral colitis is a rare inflammatory condition of the colon as a result of fecal impaction commonly located in the sigmoid colon, the rectosigmoid junction, or the anterior rectum [1]. This condition occurs commonly due to chronic constipation which results in fecal impaction and ultimately leading to inflammation of the colon. Therefore, individuals that may experience chronic constipation such as the elderly, patients with dementia, bed bound patients, or patients with coexisting psychological conditions are the most commonly affected populations. This condition is also more prevalent in females than males [2].

Stercoral colitis carries a high mortality and morbidity risk due to potential complications. The most worrisome complication of stercoral colitis is colonic perforation which carries a mortality rate of 32-60%. Since stercoral colitis can present with vague symptoms, a high index of suspicion is required to properly diagnose and treat before complications like perforation occur [3].

If peritoneal signs are present, a bedside upright chest radiograph can assess for pneumoperitoneum due to perforation which is indicated by free intraperitoneal air under the diaphragm. Further evaluation for stercoral colitis would consist of a CT with IV contrast, as this is the gold standard [4]. A CT indicative of stercoral colitis would show excessive feces in the sigmoid, colorectal, and/or rectum. Finally, another smaller study showed length of colonic involvement to correlate to higher morbidity and mortality [5].

Case

A 59-year-old female with a history of hypertension

presented with a complaint of progressively worsening abdominal distention and pain and pain in the rectal area. The patient was initially admitted to the hospital for a total vaginal hysterectomy with bilateral salpingectomy and bilateral uterosacral ligament suspension and developed these symptoms on post-op day 5. The patient was on a full hospital diet, stating she was able to initially tolerate it well but progressively experienced a loss of appetite. She had not had a bowel movement since the day of her surgery but had been able to pass gas. She denied fever, chills, nausea, and vomiting. She also reported she had no history of chronic constipation or other bowel concerns.

On surgical consult, the patient was found to have vitals within normal limits and a CMP with no abnormalities. Upon physical examination of the abdomen, it was not distended with hypoactive bowel sounds, soft, nontender, and without rebound, guarding, or rigidity. There were no other significant physical examination findings. No lactate levels, ABG, or acute phase reactants were obtained based on the benign abdominal exam findings. The patient obtained a CXR and CT with IV contrast. The CXR findings did not display any signs of pneumoperitoneum which could have indicated a bowel perforation; the CXR had no pertinent findings. The patient's pertinent CT findings consisted of moderate retained stool with fecal impaction more prominent in the rectosigmoid region as well as circumferential rectal soft tissue thickening consistent with stercoral colitis.

In accordance with the findings above, the patient did not require surgery and therefore received conservative medical treatment instead. The patient was treated with



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medical therapy of Colace, Miralax, Fleets Enema, and Fleet Mineral Oil Enema. Following medical therapy, the patient had return of bowel function and resolution of symptoms. She was with instructions to increase plant based/fiber in the diet and to follow up with GI outpatient for a colonoscopy.

Discussion

While stercoral colitis itself is rare, the cause of stercoral colitis, chronic constipation, is commonly seen in various populations. Chronic constipation can lead to fecal impaction in the colon. This fecal impaction can then lead to dehydrated masses made of fecal matter called fecalomas. The fecaloma can become lodged throughout the colon, but is most commonly lodged in the rectosigmoid colon. Fecalomas can compress vasculature supplying the colon and therefore can lead to ulceration, ischemic necrosis, and perforation [6].

The presentation of patients with stercoral colitis can be highly variable. However, the commonly presenting patients are those with higher rates of chronic constipation such as elderly patients or those with chronic opioid use. The patient may be asymptomatic or complain of nonspecific abdominal pain. Due to its variable presentation, stercoral colitis can be misdiagnosed with appendicitis, diverticulitis, bowel obstruction, or other GI conditions. Therefore it is important to obtain the appropriate diagnostic imaging if stercoral colitis is on the list of potential differential diagnoses [6].

Lab values are nonspecific but are important for raising suspicion of stercoral colitis or complications of stercoral colitis. Important labs to obtain on top of a CBC and general chemistry are acute phase reactants, lactic acid, and ABG. Elevated lactic acid and anion gap metabolic acidosis are concerning for colonic ischemia or perforation which require emergent treatment [6].

Patients with concerns of peritonitis or perforation should undergo an upright chest x-ray looking for pneumoperitoneum. If there is free air present, the patient needs to have emergent surgery to repair the colon through resection of the affected area, colostomy, and Hartmann pouch. If there are no signs of peritonitis or perforation, the patient receives a CT abdominal and pelvis with IV contrast. CT imaging findings will commonly find fecalomas, focal wall thickening of the colon, potential ulcerations, a proximally dilated colon, and pericolic or perirectal fat stranding [2].

The first steps to approaching stercoral colitis is directed at preventing complications that carry high mortality such as bowel ischemia and bowel perforation. The patient is kept NPO, providing the patient with laxatives, stool softeners, enemas, and if needed, manual disimpaction. It is also important to perform serial abdominal examinations to monitor for peritonitis that would indicate a need for an emergent exploratory

laparotomy [1].

If the patient presents with or develops signs of peritonitis, emergent surgery is needed. The specifics of the surgery needed depends on the severity of the patient's bowel once an exploratory laparotomy is performed. The common findings during surgery are colonic dilation, ulcerations, generalized peritonitis, and bowel perforation. Therefore, treatment for complicated stercoral colitis is usually bowel resection of the ischemic or perforated bowel with a colostomy and Hartmann's pouch. Individuals that undergo this surgery have high mortality rates due to the risks that bowel ischemia or a perforated bowel carry in stercoral colitis. Therefore, these patients should be placed in an intensive monitoring unit postoperatively [7-10].

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