FAECALOMA OF THE RECTUM: A CASE REPORT

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INTRODUCTION

Faecaloma of the large bowel is a rare clinical problem.[1] The term faecaloma is used for conditions where faecal matter accumulates in the intestine with stagnation and increase in size, causing deformity characteristic of a tumour.[2,3] This report deals with such a case.

CASE REPORT

A 52-year-old woman presented with a two-year history of constipation necessitating the frequent use of laxatives. She had to strain to ease herself and the stools were more often loose. When well-formed, they were of a small calibre, and felt a sense of heaviness in the perineum. Haemorrhoidectomy was performed elsewhere 23 years and two years ago. General and abdominal examinations were normal. On rectal examination, the perianal skin was lax and had two radial scars of previous haemorrhoidectomy; anal sphincteric tone was normal; high up in the rectum, a hard smooth freely moveable rounded mass was felt. Sigmoidoscopy revealed a dark brown smooth mass obstructing the rectal ampulla. Routine laboratory investigations and thyroid function tests were normal. A plain X-ray of the abdomen showed a rounded mass in the pelvis of 10 cm in diameter with a whorled calcific shadow (Fig. 1).

A barium enema revealed a large rounded mass in a dilated rectal ampulla and the rest of the large bowl were normal (Fig. 2).

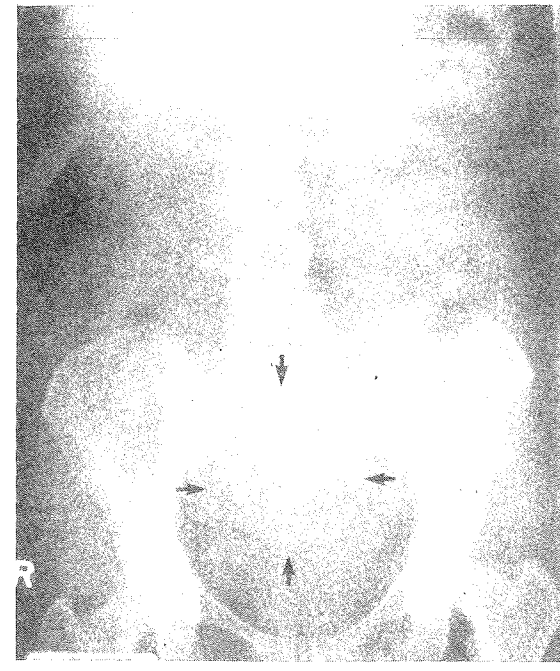

Fig. 1 **Plain X-ray abdomen showing a whorled calcific shadow in the pelvis.**

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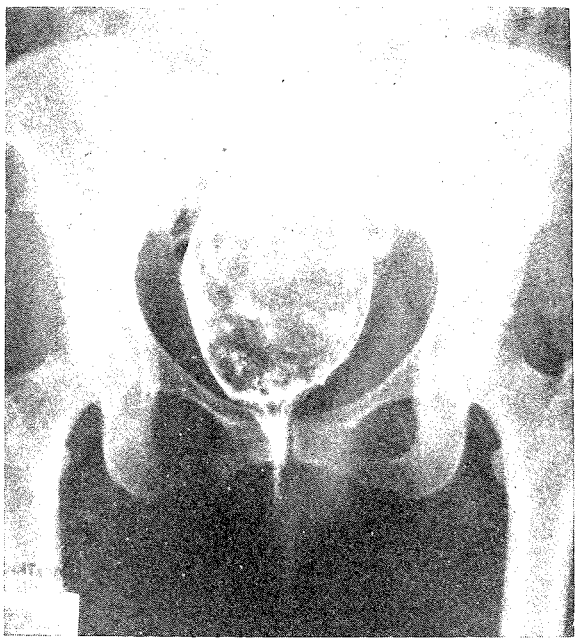

Fig. 2 **Barium enema showing a large rounded mass in the rectal ampulla.**

A biopsy of the rectal wall showed the presence of neural elements and gangilia. A diagnosis of faecaloma was made and under general anaesthesia, manual dilatation of the anus was performed. Attempts were made to extract this rounded mass intact, but was found to stretch the anus to an extent of causing damage. This mass was then fixed using a screw, fragmented and extracted piece meal. It weighed 440 g. Post-operative recovery was uneventful and subsequently followed up for one year, when she was found to have a comfortable bowel opening daily of natural calibre and consistency.

DISCUSSION

Faecaloma is a tumour-like mass of faeces. The common site of occurrence are in rectum and distal large bowel.[2] Faecaloma is usually a large smooth hard intraluminal mass with no attachment to the bowel wall and has free mobility. When they attain a large size, they tend to become immobile or fixed. The size and weight may vary widely. The contents of the mass are inconstant, usually they are of faecal matter and intestinal debris. An unusual case where the impaction had occurred due to cactus seeds, a habit amongst some North American Indian tribes, who imbibe this as a traditional remedy. The foreign material may be the nidus around which faecaloma forms. In some cases,[3] as in ours laminated calcific deposits are seen (Fig. 1).

The clinical manifestation of symptoms are of gradual onset of intermittent intestinal obstruction. Some patients may have diarrhoea caused by congestion, irrigation and ulceration of the bowel mucosa produced by excessive mucus which soften the faecal matter. A palpable indentable mass may be felt on abdominal examination. Occasionally the mass may be felt on rectal examination, in such cases it may be accompanied by tenesmus. Large faecalomas are known to press on adjacent organs producing urinary and other symptoms.[1]

Various etiological features have been implicated, such as constipation, neurological, psychological, megacolon and minor obstruction. Intrinsic dysfunction of the bowel and delayed passage of luminal contents are the two factors perhaps acting together causing the gradual formation of faecaloma.

Complications include mucosal ulceration, perforation at the site of impaction and caecal infarction to a distal obstructing faecaloma.[1] Diagnosis of faecaloma is by means of radiography. On a plain X-ray of the abdomen, faecaloma has characteristic appearance of irregular mottling or concentric layers of calcification. A barium enema would reveal a large smooth-filling defect and a normal mucosal pattern with no obstruction to the flow of barium proximally.

Faecaloma could be managed by non-surgical measures using enema containing wetting agents like dioctyl sodium succinate[2,3] or hypotonic water soluble contrast media[1] which acts by drawing water and softening the faecal mass. Surgical measures are of use in the event of failure of the above or in intestinal obstruction. Faecaloma around the rectal region are better removed manually through the anal canal by fragmentation.

REFERENCES

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