

An Unusual Mass at the Colonic Splenic Flexure

Salih Samo* and Srinadh Komanduri

Northwestern University Feinberg School of Medicine, 333 East Ontario Street, Unit 4205, Chicago, IL 60611, USA

*Corresponding author: Salih Samo, MD, Northwestern University Feinberg School of Medicine, Address: 333 East Ontario Street, Unit 4205, Chicago, IL 60611, USA, E-mail id: salih samo@hotmail.com

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Introduction

Large bowel obstruction is less common than small bowel obstruction and constitutes about 25% of intestinal obstruction [1]. Chronic functional bowel obstruction can lead to fecal impaction and subsequent fecaloma formation. We report a case of large bowel obstruction secondary to a large fecal mass at an unusual place at the colonic splenic flexure that was initially concerning for malignancy.

Case Information

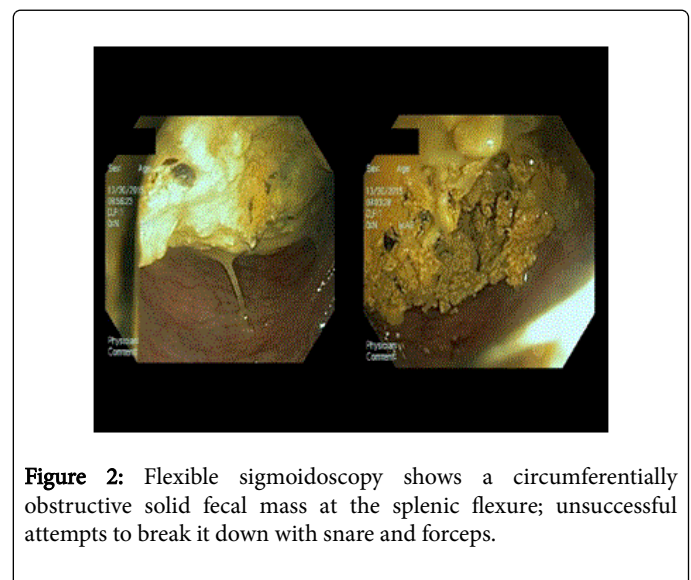
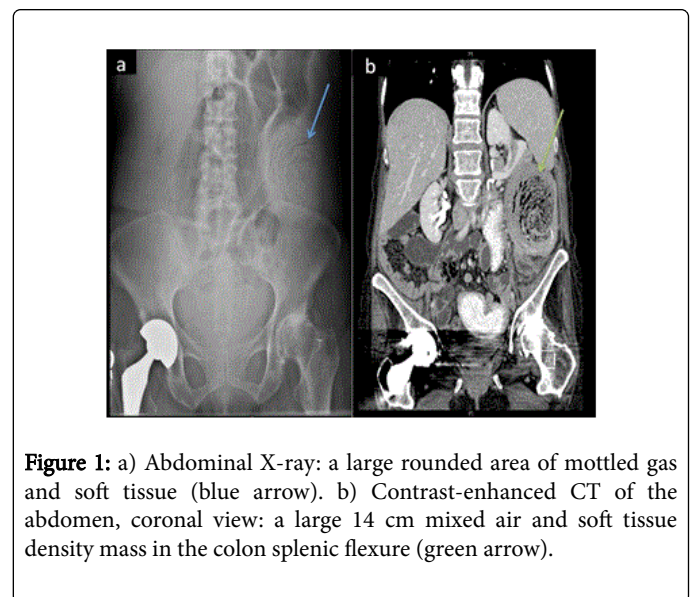
A 56 year-old female with history of irritable bowel syndrome, polymyositis and chronic intestinal pseudo-obstruction (on chronic total parenteral nutrition) presented with 2-week duration of left lower quadrant abdominal pain, nausea, vomiting, and diarrhea (dark green stools).

She also reported a history of chronic constipation and narcotics use for her chronic hip pain. Abdominal examination was notable for left lower quadrant tenderness and a left upper quadrant palpable mass.

Abdominal X-ray showed, in addition to a few air filled dilated bowel loops consistent with partial bowel obstruction, a large mass in the left hemi-abdomen suspicious for malignancy (Figure 1a, blue arrow). A contrast-enhanced computed tomography (CT) scan of the abdomen showed diffuse dilatation of the proximal and mid small bowel with decompression of more distal loops; it also showed a large 14 cm mixed air and soft tissue density mass in the colonic splenic flexure (Figure 1b, green arrow). Flexible sigmoidoscopy revealed circumferentially obstructive solid fecal mass at the splenic flexure (Figure 2) with unsuccessful attempts to break it down with snare and forceps.

Patient received multiple laxative and stool softener regimens without improvement; repeat flexible sigmoidoscopy did not reveal any significant change in the size of the fecal mass. A repeat abdominal CT scan showed worsening of the colonic obstruction proximal to the fecal mass with a new transition point.

After failed medical and endoscopic management, she underwent surgical removal of the fecal mass, sigmoidectomy with diverting loop ileostomy. She was eventually discharged to a rehabilitation institution.



Discussion

Fecaloma is an organized intraluminal fecal mass that is formed secondary to prolonged retention of fecal residue. Fecaloma is the most severe form of fecal impaction in predisposed individuals [2] and most commonly found in the recto-sigmoid area as stool becomes more consolidated due to decreased fluid content in the distal colon [3]. The

unusual site of the fecal mass at the colonic splenic flexure in this case was initially concerning for malignancy. Fecaloma may lead to specious diarrhea, bowel obstruction [4], stercoral colon ulceration and perforation [5], and urinary tract obstruction and hydronephrosis [6]. Surgical removal with limited or more extensive resection is required when conservative management fails to adequately remove fecalomas. The chronic pseudo-obstruction and low colonic transit in addition to chronic narcotic use in the patient in this case likely predisposed her to chronic fecal impaction and subsequently developing large fecaloma.

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