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CASE STUDY

FECALITH IN THE ILEUM CAUSING OF INTESTINAL OBSTRUCTION

***Dr. Rajesh, Dr. Vishal Kashyap, Dr. Deepak, Dr. Amrisha, Dr. Arpana, Dr. Anup, Dr. Satish and Dr. Vishnu**

Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, India

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ABSTRACT

Small bowel obstruction is one of the common conditions presenting in surgical wards, however fecalith is one of the rare causes of bowel obstruction. We present here a case of 12 years old boy, who presented with sub-acute intestinal obstruction. Exploratory laparotomy revealed a fecalith in ileum which was retrieved through an enterotomy and primary closure was done. The patient recovered uneventfully. Thus emphasizing the need of through history and workup which steer us to the correct diagnosis.

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INTRODUCTION

One of the less common causes of small bowel obstruction is a fecalith (Webster *et al*., 2014), usually involving the descending colon or rectum. A fecalith can also be found in the caecum or other parts of the colon1 and the main causes are congenital deformity of body2 or gut and diverticular disease (Webster *et al*., 2014; Wong *et al*., 1996; Rajput *et al*., 2007; Kumar and Sando, 2005). Although a fecalith causing intestinal obstruction in the ileum is rare (Nyberg and Sutherland, 2000), we are reporting a case of small bowel obstruction secondary to fecalith impaction in the terminal ileum.

Case report

A 12 years old male presented through the Emergency Department with the presenting complains of constipation for 10 days and abdominal pain and distension for 7 days. Initially the patient was unable to pass stools only but after 3 days he was neither able to pass faeces nor flatus. Abdominal pain and distension followed which was a gradual in onset, progressive, dull ache, initially more in the lower abdomen but it then involved the whole abdomen. This was associated with projectile, watery, yellow coloured vomitus. There is no history of fever, jaundice etc. On examination he had a pulse of 98 beats/min, BP of 130/70 mmHg and was afebrile. Abdomen was distended, firm, and mildly tender all over. Gut sounds were sluggish. DRE revealed an empty rectum. Baseline labs were within normal limits. Erect CXR and supine abdominal X-ray were ordered and showed dilated bowel loops with twisting of the sigmoid. A working diagnosis of sigmoid volvulus was made. Endoscopic decompression was attempted and a rectal tube was placed. The patient was asymptomatic for 2 days but after removal of rectal tube he again developed progressive abdominal distension and so an exploratory laparotomy was done on the 5th day of admission. A massively dilated gut from stomach to ileum was found and a stone was palpable 3 feet proximal to iliocolic junction. An incision was given over it by means of diathermy stone in pieces were retrieved Milking of the gut was done and around 2 liters of feculent material was aspirated. The ileum was closed in two layers, the cavity was washed and a drain was placed. A biopsy of the stone showed acellular material only. The drain was removed on the 2nd post-operative day. Return of bowel functions was observed on the same day.

****Corresponding author: Dr. Rajesh,***
Rajendra Institute of Medical Sciences, Ranchi, Jharkhand, India

DISCUSSION

Mechanical or functional obstruction of the small bowel eventually results in a condition called small bowel obstruction (SBO). This is a common clinical condition and 20% of admissions for acute abdominal pain are due to this condition. (Foster *et al*., 2006; Klaus Bielefeldt and Anthony J. Bauer, 2011) Small bowel obstruction due to post-operative bands and adhesions is not uncommon.

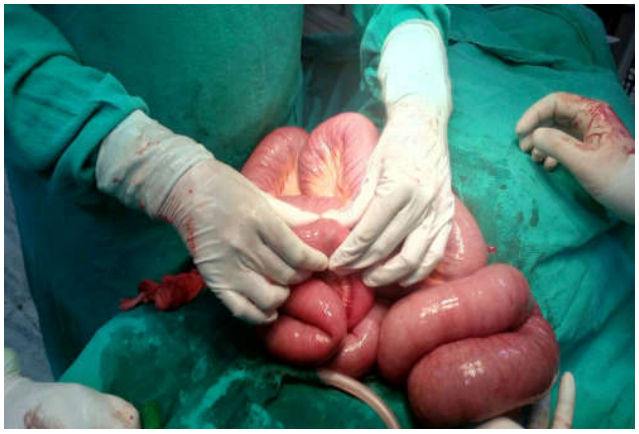

Fig. 1. Ficalith in ileum

Fig. 2. Enterotomy done

Hernias, bands, congenital or acquired, tuberculosis, lymphomas and inflammatory bowel disease are other common causes of small bowel obstruction Furthermore, gallstone, worm bolus, bezoars are intraluminal causes of intestinal obstruction. A fecalith or enterolith, however, is a very uncommon cause of small bowel obstruction in an apparently normal gut with mild adhesions. (Chowdhury *et al*., 2009) Fecalith is defined as a concretion of dry compact faeces formed in the intestine or vermiform appendix. Typically, the presenting complains of faecal impaction are very similar to that of intestinal obstruction. These include but are not limited to constipation, abdominal pain and distension, nausea, vomiting, and anorexia. After compiling a detailed history and conducting a thorough physical examination, plain abdominal films are indicated to investigate anyintraluminal faeces or signs of obstruction. (Araghizadeh, 2005; Hussain *et al*., 2014) USG and CT scans are useful in the diagnoses of jejunalenteroliths (Kumar and Sando, 2005; Klaus Bielefeldt and Anthony J. Bauer, 2011; Chowdhury *et al*., 2009) and may prove of some help in ileal stones. Treatment for ileal decompression should ideally be personalized in the setting of faecal impaction depending on the cause and patient factors (Springer *et al*., 2014; Zhao and Ke, 2010) such as in our case where initially non-surgical intervention was planned. Surgical treatment of fecalith should be planned if conservative treatment (Springer *et al*., 2014) with gastrointestinal decompression, rehydration and correction of electrolytes imbalances fails. Laparotomy and milking of enteroliths distally into the colon, crushing or enterotomy are adequate in most cases (Chowdhury *et al*., 2009) as it proved to be the main course of treatment in our case as well. Seriously ill patients benefit from resection of the diseased bowel with primary anastomosis and colon resection should be considered in recurrent cases associated with megacolon. (Chowdhury *et al*., 2009; Hussain *et al*., 2014) In conclusion, proper initial diagnosis and management of the condition can prevent much unnecessary suffering, many laparotomies and even colostomies. (Sarsu *et al*., 2014)

Conflict of interests

The authors declare that there is no conflict of interests regarding the publication of this paper.

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