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Diagnosis, Pathophysiology and Management of Stercoral Colitis

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Abstract

Stercolitis,[1] also known as stercoral colitis, is a serious inflammatory condition of the colon caused by pressure necrosis from impacted fecal matter. The term derives from the Latin "stercus" (feces) and "-itis" (inflammation). This condition occurs when hardened stool masses (fecoliths) remain lodged in the colon for extended periods, leading to ischemia, ulceration, and potentially life-threatening perforation of the bowel wall. Prognosis correlates directly with the timing of diagnosis and intervention.

Early recognition and treatment significantly improve outcomes, while delayed diagnosis with perforation carries substantial mortality risk.

Introduction

Patients with Stercolitis typically present with lower abdominal pain, distension, nausea, and vomiting. However, symptoms can be nonspecific, making diagnosis challenging. Fever and signs of systemic infection may indicate complications such as perforation or peritonitis. Some patients may report chronic constipation or paradoxical diarrhea resulting from liquid stool passing around the impacted mass.

Stercolitis predominantly affects elderly patients, particularly those with limited mobility,chronic constipation, or neurological conditions affecting bowel motility.

Risk factors include prolonged use of medications that slow intestinal transit (such as opioids, anticholinergics, and certain antidepressants), dehydration, and conditions causing altered mental status that prevent normal toileting behaviors.

Prevention focuses on maintaining regular bowel habits, adequate hydration, appropriate use of stool softeners in at-risk populations, early treatment of constipation, and regular monitoring of elderly or immobilized patients.

Pathophysiology

The underlying mechanism of stercolitis involves chronic fecal impaction, which creates sustained pressure on the colonic mucosa.

Stercoral colitis is an inflammatory bowel disease resulting from the development of impacted stool and fecalomas. This extensive stool burden in-

creases the intraluminal pressure of the large bowel. The high intraluminal pressure causes pressure ulceration of the bowel wall and decreased bowel perfusion, which leads to bowel wall perforation. Approximately 27 % of patients will develop focal ulceration in multiple areas, typically in adjacent areas to the fecaloma. The rectosigmoid colon is most commonly affected, with its antimesenteric border particularly predisposed to ulcerations due to its narrow lumen diameter and vasculature; it is a watershed region between the inferior mesenteric and superior rectal arteries and the blood flow enters from the mesenteric side. Perforation of the bowel wall allows spillage of intraluminal contents into the peritoneal cavity, which can result in sepsis and death. Chronic constipation or fecal impaction.

This pressure compromises blood flow to the affected tissue, resulting in ischemic injury and subsequent inflammation. The rectosigmoid region is most commonly affected due to its narrower diameter and the natural tendency for stool to accumulate in this area. As the condition progresses, the compromised tissue becomes

vulnerable to bacterial invasion, potentially leading to transmural necrosis and perforation. Perforation may lead to fecal peritonitis, sepsis, and multiorgan failure if not promptly addressed. Other complications include abscess formation, stricture development, and massive gastrointestinal bleeding.

Risk Factors

Common risk factors for stercoral colitis include older age and chronic constipation. Chronic constipation affects over one-third of patients over 60 years, with females more commonly affected. Given the role of large quantities of impacted stool in the pathophysiology of the disease, medical conditions and lifestyle choices predisposing to constipation also serve as risk factors for the disease. These include obesity; diets low in fiber; patients with residual deficits from cerebrovascular accidents, spinal cord injuries or other traumatic injuries; immobility; deconditioning; nursing home residents; Parkinson's disease; diabetic enteropathy; cerebral palsy; Hirschsprung's disease; and any other chronic metabolic, neurologic, or muscular disease that affects mobility or bowel habits.

Additionally, the use of medications that may contribute to constipation is a risk factor for stercoral colitis .

Risk Factors Summary

Risk Factors

Chronic constipation or fecal impaction; Chronic constipation should never be ignored, particularly in elderly or debilitated patients. Regular bowel management and early intervention for severe constipation can prevent this life-threatening complication.

- Advanced age
- Neurological disorders (Parkinson's, dementia, spinal cord injury)
- Medications that slow gut motility (opioids, anticholinergics)
- Immobility or bedridden status
- Psychiatric conditions
- Chronic kidney disease

Diagnosis and Complications

Diagnosis requires a high index of suspicion and appropriate imaging. Plain radiographs may show fecal loading but are less sensitive for detecting inflammatory changes or perforation. The most

feared complication is colonic perforation, which carries significant mortality rates reported between 32% and 57% in various studies. Abdominal computed tomography (CT) is the gold standard, revealing fecal impaction with associated colonic wall thickening, inflammation, and potential complications.

Management

Management consists of disimpaction, colon evacuation, and a maintenance bowel program to prevent recurrent impactions.

Treatment options include gentle proximal softening in the absence of complete bowel obstruction, distal washout, and manual extraction. Surgical intervention is indicated when perforation occurs or conservative measures fail. Surgical resection of the involved colon or rectum is reserved for cases of Fecal impaction complicated by ulceration and perforation leading to peritonitis. Procedures range from primary repair with diverting colostomy to segmental resection of necrotic bowel. The Hartmann procedure (resection with end colostomy) is commonly performed in emergency settings, with potential reversal once the patient.

Fecal impaction (FI) is a common cause of lower gastrointestinal tract obstruction lagging behind stricture for diverticulitis and colon cancer. It is the result of chronic or severe constipation and most commonly found in the elderly population.

Early recognition and diagnosis is accomplished by way of an adequate history and physical examination in conjunction with an acute abdominal series.

Prompt identification and treatment minimizes the risks of complications such as bowel obstruction leading to aspiration, stercoral ulcers, perforation, and peritonitis. Treatment options include gentle proximal softening in the absence of complete bowel obstruction, distal washout, and manual extraction. Surgical resection of the involved colon or rectum is reserved for cases of Fecal Impaction complicated by ulceration and perforation leading to peritonitis. Recurrence is common, and can be managed by increasing dietary fiber content to 30 gm/day, increased water intake, and discontinuation of medications that can contribute to colonic hypomotility.

Recurrence of constipation induced fecal impactions are common and can be managed by increasing dietary fiber intake to 30 g/day, increasing water intake, and discontinuing medications that may contribute to colonic hypomotility. Treatment depends on disease severity and the presence of complications. Conservative management includes disimpaction, aggressive bowel regimens with laxatives and enemas, hydration, and discontinuation of constipating medications.

Conclusion

Chronic constipation and fecal impactions should never be ignored, particularly in elderly or debilitated patients. Regular bowel management and early intervention for severe constipation can prevent this life-threatening complication.

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