AB167. 34. Slow and study loses the race: case study of stercoral perforation

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Background: Stercoral perforation is an uncommon cause of colonic perforation, despites views to the contrary. Its presentation frequently differs from other causes of colonic perforation as patients are generally well preceding the event are often not anticipated. There are less than 100 cases reported in the literature citing Stercoral Perforation. This case report describes a 73-year-old lady, who presented to us with this pathology.

Methods: A 73-year-old female presented to Emergency Department with 12-hour history of generalised abdominal pain, associated with nausea and vomiting. She described a 3-day history of absolute constipation. Her past medical history includes mild dementia, chronic kidney disease (CKD), diabetes insipidus, depression and traumatic intracranial bleed 4 months ago, for which she was admitted in intensive care unit (ICU) department (Cork University Hospital) for about 2 months. The patient was septic on presentation, with heart rate (HR 122 bpm), hypotensive (85/55) and febrile (38.2 ℃). Her abdomen was generalised distended & rigid, with diminished bowel sounds. Urine output was less than 5 mL per hour. C-reactive protein (CRP) was 470, but surprisingly whey protein concentration (WBC) were 5.6. Patient was not stable enough for computed tomography (CT) scan, despite aggressive resuscitation, so she was transferred to ICU. Further dropped in her blood pressure (BP), made decision to proceed for emergency laparotomy.

Results: Intraoperatively we found multiple hard clumps of faeces in the abdominal cavity with a single sigmoid perforation. There was no evidence of diverticular change or other colonic pathology. A diagnosis of Stercoral perforation was made. Patient underwent Hartman's procedure. Post operatively, she did extremely well and was discharged home with the multi-disciplinary input from dietician, physiotherapist, stoma care.

Conclusions: Stercoral perforation is a rare aetiology, which affects antimesenteric side of sigmoid colon and recto-sigmoid junction with colonic perforation size of more than 1cm, with faecalomas in the cavity Stercoral. If delay in presentation & diagnosis, it can lead to a high mortality rate, especially in the older and immobilised patient. There are only 98 cases reported in literature so far. CT scan is radiological investigation of choice, and surgery is key to survival. Stercoral perforation differs other pathologies causing bowel leak, as there usually is an absence of an inflammatory component (diverticulitis, IBD, ischaemia, obstruction, post-operative, trauma). Follow up colonoscopy is advisable in 6–12 months post-surgery.

Keywords: Diagnosis; management; pre-post operative plans

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