

## Endoscopic evolution of rectal stercoral ulcer presenting with a large bleeding pseudodiverticulum in a patient with chronic constipation

An 80-year-old man with a longstanding history of constipation reported passage of bloody stool for 7 days. His constipation had also worsened, requiring frequent enema in the past 1 month. His past medical history included benign prostate hypertrophy. On physical examination, his conjunctivae were pale and there was marked tenderness in the lower abdomen. His hemoglobin was 7.2 g/dL. A plain radiograph of the abdomen showed large amounts of hard feces in the colon and rectum. An urgent sigmoidoscopy following gentle rectal irrigation showed a large, wide-mouthed, diverticulum-like lesion, with extensive ulceration with adherent blood clots in the rectum (● Fig. 1). There was also a fistulous communication between the pseudodiverticular lesion and the rectum (● Fig. 2). Endoscopic injection therapy was successfully carried out, and histopathologic examination of biopsy specimens taken from the rectal lesion demonstrated acute and chronic inflammatory change of the mucosa, but there was no evidence of malignancy. The patient was administered 3 units of packed red blood cells and stool softeners and laxatives. A repeat sigmoidoscopy 1 week later still showed retained stools in the rectum and colon after rectal enema. Endoscopy revealed an outpouching rectal lesion (● Fig. 3) with granulation tissue within the lesion (● Fig. 4), however, there was no evidence of rectal bleeding. A follow-up sigmoidoscopy 10 months later revealed normal mucosa in the rectum with no evidence of the pseudodiverticular lesion.

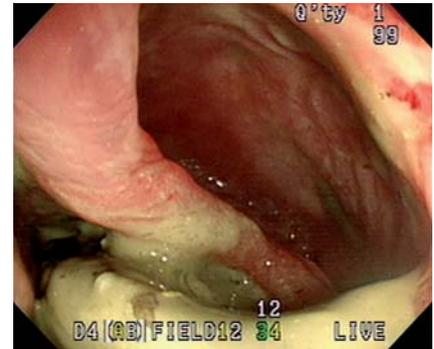
Stercoral ulceration was first described as a distinct entity by Berry in 1894 [1] and results from pressure necrosis of the bowel wall induced by impacted inspissated feces. It usually occurs in elderly people with a history of chronic constipation and



**Fig. 1** Endoscopic view showing a large, wide-mouthed, diverticulum-like lesion with extensive ulceration with adherent blood clots in the rectum.



**Fig. 2** Endoscopic view showing a fistulous communication between the pseudodiverticular lesion and the rectum.



**Fig. 3** Endoscopic view showing an outpouching lesion in the rectum with retained feces.



**Fig. 4** Endoscopic view showing granulation tissue inside the pseudodiverticular lesion in the rectum.

the lesions are commonly seen in the rectum and sigmoid colon. The harder consistency of feces, the narrowed lumen, and the relatively diminished blood flow in these areas are implicated in its formation. Endoscopic investigation of stercoral ulceration characteristically demonstrates an irregular, geographic ulcer conforming to the contour of the impacted fecal mass [2]. A stercoral ulcer presenting with a bleeding pseudodiverticular lesion

as seen in our case has not been previously described. Major complications of stercoral ulcers are bleeding and perforation [3,4]. Successful endoscopic hemostasis in cases of bleeding with endoscopic multipolar electrocoagulation and injection therapy has been reported [3,5].

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**Competing interests:** None

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