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Case Report

When labour meets a hard stop: a case report of recurrent giant fecaloma in pregnancy

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ABSTRACT

Although severe constipation is common during pregnancy, a giant fecal impaction causing pelvic obstruction is exceedingly rare. There has been no previous report of recurrence across pregnancies associated with severe fetal growth restriction. A 22-year-old gravida 2 para 1 with lifelong severe functional constipation and a history of abuse presented twice with a giant rectosigmoid fecaloma. In her first pregnancy, magnetic resonance imaging at 19 weeks demonstrated massive stercoral dilation (12×12×35 cm) displacing the uterus. Partial medical bowel preparation was insufficient and manual disimpaction enabled operative vaginal delivery of a severely growth-restricted neonate. The patient declined digestive investigations after delivery. During her second pregnancy, she again had a large fecaloma with uterine displacement and severe fetal growth restriction. Repeated medical bowel preparation failed, necessitating manual disimpaction, and induction was initiated immediately. Placental histology revealed fetal vascular malperfusion and delayed villous maturation. The recurrence of giant fecaloma highlights the need for early recognition and structured bowel management in pregnant patients with chronic severe constipation or neurodevelopmental vulnerability. Mechanical obstruction was the cause of labour difficulties, while fetal growth restriction was predominantly due to chronic placental insufficiency. Nevertheless, chronic constipation–associated dysbiosis and mechanical crowding may have contributed. The general principles of fecal impaction management apply during pregnancy. An adapted algorithm for pregnant women is proposed. Despite obstruction that can be exceptionally severe, dedicated care tailored to pregnancy and involving several specialists can help free up the pelvis and allow for a vaginal delivery.

Keywords: Fecal impaction, Constipation, Dystocia, Fetal growth restriction, Psychosocial factors, Magnetic resonance imaging

INTRODUCTION

Constipation is among the most common gastrointestinal complaints in pregnancy, affecting 30–40% of women, with prevalence estimates ranging from 11% to 39% depending on diagnostic criteria and gestational timing.[1,2] It typically develops during the first and second trimesters because of hormonal, mechanical, and behavioural factors. Progesterone-induced relaxation of gastrointestinal smooth muscle slows intestinal transit, while reduced physical activity and increased colonic water absorption further contribute to stool hardening.[2] The impact of iron supplementation on bowel motility remains debated and constipation may become more frequent with increasing parity.[3,4] In most cases, pregnancy-related constipation is

mild and self-limited, responding to dietary fibre, hydration, and safe osmotic laxatives. However, severe or neglected cases may lead to serious complications such as fecal impaction, stercoral colitis or perforation, stercoral ulceration, urinary retention, or mechanical dystocia during labour.[5,6]

A giant fecaloma compressing the pelvic outlet is an exceptionally rare event. Since the first report in 1955 by Grasby et al,7 fewer than ten cases have been described in the literature (Resta et al, Hjortrup et al and Sheld et al), all associated with congenital or acquired megacolon, idiopathic megarectum, or dysganglionosis. To our knowledge, this is the first documented case of recurrent giant fecaloma complicating two consecutive pregnancies, both associated with severe fetal growth restriction (FGR), highlighting the diagnostic, mechanical, and vascular implications of this unusual presentation. We also discuss the psychosomatic and psychosocial dimensions of this case, which may have contributed to both bowel dysfunction and pregnancy outcomes.

CASE REPORT

A 22-year-old woman, gravida 2 para 1, with lifelong severe functional constipation and recurrent fecal impaction (fecaloma), was admitted at 37 + 4 weeks for induction of labour because of severe fetal growth restriction (estimated fetal weight <1st centile) and mild oligohydramnios, with normal Doppler studies. She had a probable mild intellectual disability, attended weekly psychological follow-up, and reported a history of abuse. Gestational weight gain (GWG) was within normal limits for the first pregnancy but low during the second (12 kg for body mass index (BMI) 17kg/m^2 and 9 kg for BMI 20kg/m^2).

First pregnancy

The diagnosis was initially suggested at 16 weeks by ultrasound (Figure 1) and subsequently refined by a global evaluation using magnetic resonance imaging (MRI) (Figure 2). The presence of a left hemi-abdominal mass was already identified on the 8-week gestational ultrasound performed by the patient's primary gynecologist.

At 19 weeks, pelvic MRI revealed massive rectosigmoid stercoral dilation (12 × 12 × 35 cm) displacing the uterus upward and to the right, with a near-transverse fetal lie, raising concern about feasibility of vaginal delivery. Despite partial improvement after intensive bowel preparation (Clyssie®, High volume soapsuds enemas), the large fecaloma persisted. The visceral surgeons were consulted and initially recommended caesarean section because of the size of the obstructing mass. Manual disimpaction under epidural analgesia was ultimately successful, enabling vaginal delivery with forceps after a prolonged deceleration. The neonate weighed 1870 g (<1st percentile) and required brief respiratory support by continuous positive airway pressure (CPAP). Postpartum gastroenterological assessment for Hirschsprung's disease was proposed but not completed.

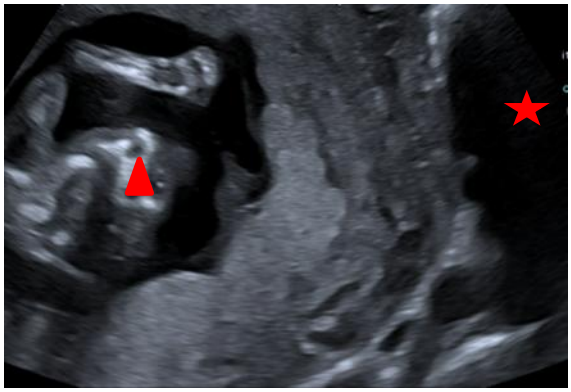
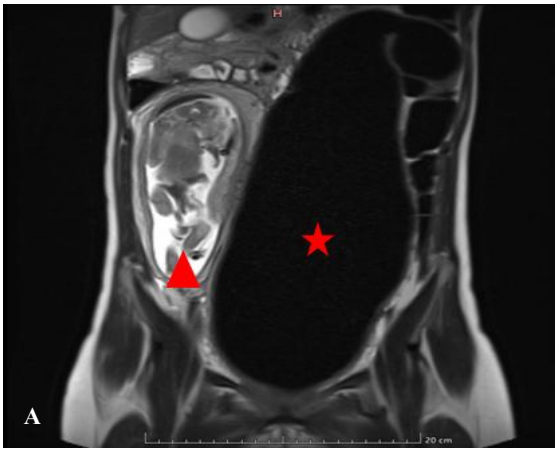


Figure 1: Ultrasound at 16 weeks gestation showing suggestion of fecaloma. Red star (★) indicates the fecaloma; red triangle (▲) indicates the fetus.



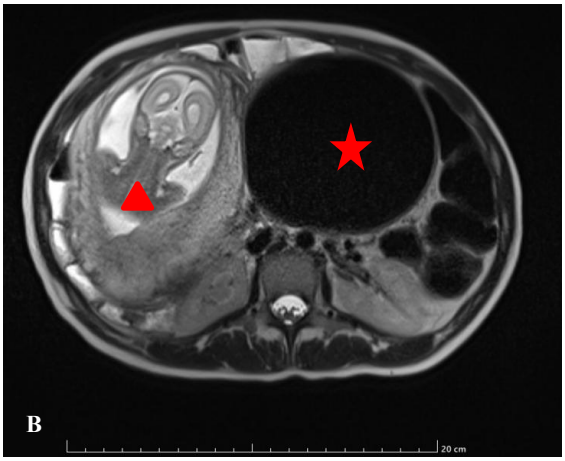


Figure 2: (A) Coronal and (B) transverse sections of a pelvic MRI at 19 weeks gestation showing massive rectosigmoid stercoral dilation (12 × 12 × 35 cm) displacing the gravid uterus to the right and completely obstructing the pelvis. Red star (★) indicates the fecaloma; red triangle (▲) indicates the fetus.

Second pregnancy

The second pregnancy was diagnosed late at 26 weeks. On the first hospital-based antenatal visit at 37+3 weeks, she was admitted for induction for severe FGR. The patient was 21 years old during her first pregnancy and 22 years old during the second one, with an interpregnancy interval of approximately 8 months. The patient reported no bowel movements for three weeks and again presented with a giant fecaloma associated with marked uterine displacement and abnormal fetal lie. Because the indication for induction was immediate, limited time was available for progressive medical bowel preparation. Despite several days of polyethylene glycol, osmotic laxatives, and enemas (Practomil ®) evacuation remains minimal, and manual disimpaction was again required. It took two hours of fecal fragmentation and removal and another large enema to achieve proper rectosigmoid emptying. Labour induction followed.

Several prolonged fetal decelerations occurred, requiring tocolysis. At full cervical dilatation, vaginal bleeding and persistent bradycardia prompted vacuum-assisted delivery for suspected placental abruption. The severely growth-restricted neonate adapted well after brief CPAP support. Placental histology demonstrated a large subamniotic haematoma involving approximately three quarters of the placental surface, delayed villous maturation, cytotrophoblastic pseudocysts, dystrophic calcifications, and features of fetal vascular malperfusion, supporting a chronic placental insufficiency mechanism. Acute stage II chorioamnionitis was also noted. A complete postpartum gastrointestinal work-up, including evaluation for Hirschsprung's disease, was arranged.

Differential diagnosis

The differential diagnosis includes various forms of intestinal dysganglionosis: agenetic (including classic Hirschsprung's disease and ultrashort-segment disease), hypogenetic/dysgenetic, or acquired forms. Acquired conditions encompass Chagas disease, as well as neurological, systemic, or metabolic affections of enteric innervation. In addition, hypomotility can be induced by medication (opioids, anticholinergics, tricyclic antidepressants, calcium-channel blockers, or antipsychotic drugs). To the best of our knowledge, there are no recommendations on the management of megacolon during pregnancy.

DISCUSSION

Severe constipation and fecal impaction are frequent in pregnancy, yet mechanical obstruction of labour by a fecaloma or megarectum remains exceptionally rare. Only a handful of cases have been reported in the literature since the 1950s. Most describe congenital or acquired forms of intestinal dysganglionosis or megacolon revealed or exacerbated during pregnancy, occasionally leading to dystocia or the need for caesarean delivery.

Across available reports, several common themes emerge. First, fecal impaction can act as a true mechanical barrier to fetal descent, particularly when the rectosigmoid segment is massively dilated. Second, delayed diagnosis especially in women with chronic constipation or neurodevelopmental disorders may allow progressive rectal distension to reach extraordinary dimensions, as observed in our patient.

Constipation management

To our knowledge, no international obstetric guideline specifically addresses megacolon or fecaloma in pregnancy. Existing recommendations focus on pregnancy-related constipation, promoting lifestyle and dietary measures as first-line therapy, with osmotic laxatives when needed. Iron supplementation, while sometimes aggravating constipation, should be individually adjusted rather than systematically avoided. We propose a simple management algorithm summarising the laxatives and enemas commonly used, along with their recommended use and safety profile during pregnancy (Table 1).

Table 1: Therapeutic options, safety, and considerations during pregnancy.

Treatment	Types	Mains concerns	Safety/Recommendations
Glycerin suppositories	Rectal, osmotic	Minimal rectal irritation	Safe / may be used as first-line rectal therapy
PEG (polyethylene glycol)	Oral, osmotic	Dose-dependant diarrhea	Safe / First-line oral treatment
Oil-based enemas (e.g Practomil®)	Rectal, lubricating	Minimal irritation	Safe / useful for distal fecal impaction
High volume soapsuds enemas	Rectal, irritant	Mucosal irritation, vagal response	Use cautiously during pregnancy
Sodium phosphate enemas	Rectal, hyperosmotic	Electrolyte disturbances, uterine stimulation	Not recommended as first-line – use with caution
Manual disimpaction	Rectal, Mechanical	Discomfort, vagal response	Safe when indicated, with appropriate monitoring and pain management

Management of giant fecaloma must therefore be adapted to pregnancy. In the diagnostic assessment of a suspected fecaloma during pregnancy, MRI is the preferred modality, as it avoids ionising radiation, provides excellent soft-tissue characterisation, accurately delineates rectosigmoid dilatation and its relationship to the gravid uterus, and helps exclude alternative causes of pelvic obstruction. MRI is considered safe at all stages of pregnancy, according to international radiological consensus guidelines (ACOG Committee Opinion No. 723, Guidelines for Diagnostic Imaging During Pregnancy and Lactation 2017).

Management of fecal impaction and potential complications

Our case also illustrates the importance of anticipatory bowel management throughout pregnancy in women with chronic constipation or neurodevelopmental disorders. Early recognition and proactive treatment may prevent massive rectal distension and its mechanical or vascular consequences. Where fecal impaction is severe, gradual medical disimpaction under close maternal–fetal surveillance should be preferred to forceful manual extraction during labour.

In severe fecal impaction, stercoral colitis may progress from focal mucosal ischemia to ulceration, transmural necrosis and perforation, with secondary peritonitis/sepsis if diagnosis is delayed (imaging and emergency-medicine series). Fecal impaction can also lead to urinary retention or infectious complications.[6] While manual disimpaction is usually effective and safe, rare vagal events (severe bradycardia/cardiac arrest) and procedure-related mucosal injury have been reported.[8–10] Enema-related perforations underline the need for gentle, well-lubricated digital fragmentation, cautious enemas, and escalation to operating-room evacuation under anaesthesia when appropriate.

Fetal surveillance during disimpaction of a giant fecaloma

A similar case was described by Figueiredo et al, in which a giant fecaloma obstructing the pelvic outlet was detected at the onset of labour, in the context of a hypoganglionosis.[11] Manual disimpaction was attempted, but a sudden and sustained fetal bradycardia occurred during the procedure, prompting an emergency caesarean section. The neonate developed hypoxic–ischaemic encephalopathy, with no other identifiable antenatal or intrapartum risk factors. The authors hypothesised a transient reduction in uteroplacental perfusion or a vagal reflex triggered by pelvic compression as the cause of the bradycardia.

This underscores the importance of continuous cardiotocographic monitoring during and after manual disimpaction or rectal manipulation in pregnant women, as fetal compromise may occur abruptly. In addition, maternal vital signs should be closely monitored. Positioning the patient in the left lateral decubitus position may also help reduce aortocaval compression and improve uteroplacental perfusion.

Delivery in case of a giant praevia fecaloma

Amorim et al reported a case of acquired megacolon with a massive fecaloma completely obstructing the pelvic outlet despite full cervical dilation.[12] At that stage, manual disimpaction was considered too difficult and hazardous, and instrumental delivery was not attempted owing to the rigidity of the obstruction. An emergency caesarean section was therefore performed, but the neonate died shortly after birth due to severe asphyxia. The authors attributed the poor outcome to the late recognition of the fecaloma and the impossibility of its removal during labour.

Importantly, a giant rectosigmoid fecaloma also poses significant challenges for caesarean delivery itself: the distended colon may limit access to the lower uterine segment, increase the risk of bowel injury during the surgery, and even compromise abdominal closure. In contrast, in our patient, recognition and planned manual evacuation under close monitoring allowed a safe vaginal delivery, demonstrating that when identified before advanced labour a multidisciplinary, but obstetrically led, conservative strategy can avoid unnecessary caesarean sections and optimise both maternal and neonatal outcomes.

Psychosocial and psychosomatic considerations

This case highlights the psychosocial and psychosomatic dimensions often intertwined with severe functional constipation. Chronic constipation and fecal impaction are well documented among individuals with psychiatric comorbidities or social vulnerability. Reduced bodily awareness, poor self-care, and delayed consultation may lead to extreme presentations.[13] Emotional distress and avoidance behaviours can perpetuate stool withholding and rectal distension through a brain–gut feedback loop, while family and socioeconomic factors further influence chronic constipation and encopresis.[14,15]

In our patient with probable mild intellectual disability, social isolation, pregnancy denial and a history of violence, these mechanisms were likely amplified. Psychosocial stress may also contribute to fetal growth restriction by activating the hypothalamic–pituitary–adrenal axis, resulting in excess cortisol, and impaired placental perfusion.[16] Finally, severe encopresis or chronic fecal retention should prompt sensitive screening for prior trauma or sexual abuse, as such experiences may manifest through avoidance of genital or rectal sensations.[17] Recognising these psychosomatic patterns is key to providing empathetic, multidisciplinary care, including appropriate psychological support, that prevents recurrence and supports maternal well-being.

Fetal growth restriction and fecaloma : a direct or indirect (microbiota, gestational weight gain) link?

In our case, the recurrent giant fecaloma acted as a "previa" mass, displacing the gravid uterus and plausibly impeding uteroplacental perfusion. Mechanical crowding may have transiently impaired pelvic venous return and uteroplacental blood flow.[18] Beyond mechanics, a microbiota-mediated pathway is biologically plausible: chronic constipation and fecal retention are associated with gut dysbiosis (altered diversity/composition) and changes in neuromuscular signalling of colonic motility; pregnancy-related constipation itself is linked to hormonal effects and dysbiosis, which may secondarily influence maternal inflammation, nutrient handling and, ultimately, placental function.[19,20] In addition, bowel obstruction/marked fecal stasis has long been thought to favour bacterial overgrowth, supporting a mechanistic bridge between severe impaction and dysbiosis.[6,21]

From a nutritional standpoint, inadequate GWG is a recognised risk factor for FGR.[22] While we found no direct study linking "fecaloma" per se to low GWG, severe chronic constipation can plausibly reduce intake (early satiety, abdominal discomfort) and is associated with lifestyle factors (low activity, low fibre/water intake) that predispose both to constipation and suboptimal GWG thus providing a potential indirect link; GWG in our patient was insufficient during second pregnancy according to IOM 2009 recommendations.[22-24]

CONCLUSION

This case extends the limited literature on giant fecaloma in pregnancy by documenting its recurrence across two consecutive pregnancies, both complicated by marked pelvic distortion, abnormal fetal lie and severe fetal growth restriction. Despite concerns regarding mechanical obstruction to vaginal delivery and potential difficulties with caesarean section, successful manual disimpaction enabled vaginal birth on both occasions. Our findings emphasise the importance of early recognition, antenatal bowel optimisation, multidisciplinary collaboration and careful maternal–fetal monitoring. The coexistence of placental vascular abnormalities highlights the need to investigate fetal growth restriction independently, whilst acknowledging possible contributions from mechanical compression, constipation-related dysbiosis and nutritional factors. Our proposed pregnancy-adapted management algorithm provides a practical framework for individualised care in this exceptionally rare situation.

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