

Case Report

# Stercoral Ulcers with Visible Vessel Presenting as Massive Lower Gastrointestinal Bleeding

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## Abstract

**Background:** Lower gastrointestinal (GI) bleeding is a significant cause of morbidity and mortality, with incidence rising with age. Stercoral ulcers, which are mucosal lesions in the colon or rectum, develop due to pressure from hardened or impacted fecal material. They primarily occur in elderly individuals with chronic constipation, dementia, or prolonged immobility, though they may also affect younger patients with psychiatric disorders. These ulcers can lead to bleeding or even perforation. While stercoral ulcers typically present with mild bleeding, massive GI haemorrhage is a rare but serious complication. Only a few reported cases describe stercoral ulcers with a visible vessel causing life-threatening lower GI bleeding. **Case presentation:** A 65-year-old woman with a history of hypertension, type 2 diabetes mellitus, and a recent ischemic stroke (resulting in left hemiparesis) on antiplatelet therapy presented with worsening chronic constipation and acute onset hematochezia. On examination, fecal impaction was suspected. Initial management with fluid resuscitation, blood transfusion, and manual fecal disimpaction was done. Subsequent sigmoidoscopy revealed multiple rectal ulcers of varying shapes and sizes, with one ulcer exhibiting a non-bleeding visible vessel. The lesion was successfully treated with endoscopic gold probe electrocoagulation, followed by haemostatic clip application to secure the vessel. The patient had no further bleeding episodes post-intervention. **Conclusion:** This case underscores the importance of proactive constipation management in elderly, bedridden patients, particularly those with multiple comorbidities and on antiplatelet therapy. Early recognition and intervention for stercoral ulcers are essential to prevent life-threatening complications such as massive gastrointestinal hemorrhage or perforation. Endoscopic therapy, including electrocoagulation and clipping, can be an effective approach for achieving hemostasis in such scenarios.

## Keywords

Stercoral Ulcer, Massive Lower GI Bleed, Constipation

## 1. Introduction

Stercoral ulcers are lesions in the mucous membrane of the colon and rectum caused by pressure of inspissated or im-

packed fecal mass, may present with either bleeding or perforation [1]. It occurs anywhere in colon, but the most common

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**Received:** 3 April 2025; **Accepted:** 14 April 2025; **Published:** 24 May 2025

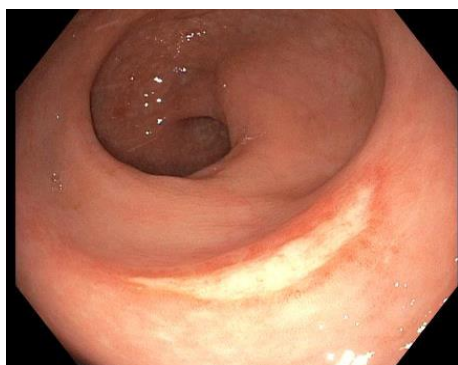


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locations of ulceration are in the recto-sigmoid area, narrowest part of colon. Stercoral ulcers most often occurs in patients with a history of chronic constipation, elderly patients with dementia, nursing home or bedbound patients, and occasionally young patients with psychiatric conditions [2]. Massive gastrointestinal bleeding is a rare presentation [3]. We are reporting a patient who presented with massive hematochezia caused by a stercoral ulceration with a visible vessel of the rectum. Stool dis-impaction followed by endoscopic electro-coagulation and hemostatic clipping was performed and no further bleeding occurred. To our knowledge, there were only few case reports of a visible vessel in a stercoral ulcer.

## 2. Case Description

A 65-year-old lady, a known case of primary hypertension, Type 2 diabetes mellitus and recent ischemic stroke on antiplatelets presented to our emergency department with chief complaints of bleeding per rectum of 2 days duration. She also had constipation for 1 year which had worsened since last 2 months despite medication. On examination, she had pallor, tachycardia, borderline hypotension, tenderness in left lower abdomen and residual left hemiparesis. On evaluation, she had anemia with hemoglobin of 8 gm/dl, leukocytosis (WBC-12500/mm<sup>3</sup>) and deranged renal parameters (Urea – 94 mg/dl, Creatinine - 1.6 mg/dl). She was managed with intravenous crystalloids, parenteral antibiotics and 2 units of PRBC transfusion. Her antiplatelet medication stopped on day 1 of the presentation. Per rectal examination and sigmoidoscopy showed impacted stool in the rectum. Surgery consultation taken and stool disimpaction was done. Repeat sigmoidoscopy showed large blood clot in the rectum with multiple ulcers of various shapes and sizes (Figures 1, 2 and 3). One small ulcer also showed a non-bleeding visible vessel (Figure 2). Gold probe coagulation (Figure 4) followed by hemostatic clipping of visible vessel was done (Figure 5). No further bleeding happened during hospital stay and patient was discharged on laxatives. Her antiplatelet medication was re-introduced on day 7 of bleed.



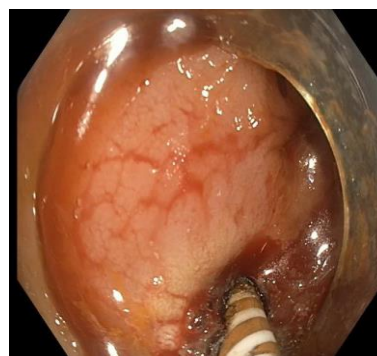
**Figure 1.** Clean based rectal ulcer.



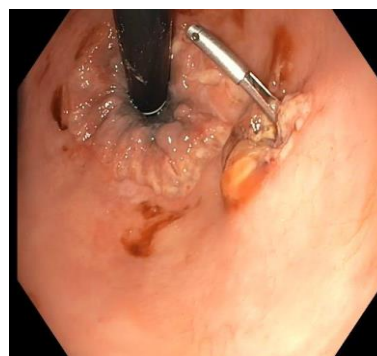
**Figure 2.** Non bleeding rectal ulcer with visible vessel.



**Figure 3.** Clean based rectal ulcer.



**Figure 4.** Bipolar thermal coagulation using Gold probe.



**Figure 5.** Endoclip application over visible vessel.

### 3. Discussion

Lower gastrointestinal bleeding (LGIB) is a significant worldwide cause of morbidity and mortality. The incidence of LGIB increases with age and corresponds to three more factors common in the elderly viz. increased incidence of gastrointestinal disease specific to elderly patients, comorbid diseases and polypharmacy [4]. Worldwide, there is a wide variation in the reported causes of LGIB and the common causes include diverticulosis, hemorrhoids, carcinoma colon, inflammatory bowel disease, ischemic colitis, angiodysplasia, polyps, infective colitis, radiation proctitis, solitary rectal ulcer syndrome, stercoral ulcers etc. [5, 6]. Our index patient had massive lower gastrointestinal bleeding due to stercoral ulcer with visible vessel.

Stercoral ulceration was first described by Berry in 1984 [7]. Pathologically, the ulcer is characterized as an ischemic pressure necrosis due to a hard fecal mass, causing an irregular geographically outlined ulcer that conforms to the contour of the impacted fecal mass. These ulcers are often multiple and typically occur on the antimesenteric side of the bowel, likely because the blood supply arises from the mesentery making the antimesenteric side more vulnerable to ischemia. 77% of stercoral ulcerations are found in the sigmoid colon or rectum due to decreased water content of the stool, relatively poor blood supply, narrow caliber and high intraluminal pressure [8]. The incidence is unknown among the general population and massive bleeding is an exceedingly rare complication. Stercoral ulcer must be considered as an etiology of lower gastrointestinal bleeding, especially in elderly bedbound patients with chronic constipation. It may sometimes present as a sudden onset of massive lower gastrointestinal bleeding, most commonly in hospitalized, bedridden patients [9, 10]. Mortality depends on underlying comorbidities and severity of bleeding.

Management includes fecal dis-impaction either by rectal enema or manually. Further management depends on endoscopic findings and may require endoscopic injection therapy or electro coagulation or haemostatic clips or combination therapy [11]. Surgical intervention is indicated if endoscopic measures fail to control bleeding. To the best of our knowledge there are only a few cases of stercoral ulceration with visible vessel reported in literature [12].

### 4. Conclusion

Constipation is the most common risk factor for stercoral ulcers especially in elderly bedbound patients. Management of constipation in these patients is of utmost importance to prevent complications like stercoral ulcer bleeding, intestinal obstruction and perforation. Bleeding from stercoral ulcer should be considered in bedbound elderly patients with history of constipation. Management includes fecal dis-impaction followed by endoscopic therapies including local adrenaline injection, electrocoagulation and hemostatic clip application. Surgical intervention may be required in isolated cases.

### Abbreviations

LGIB	Lower Gastrointestinal Bleeding
GI	Gastrointestinal

### Informed Consent

Informed consent was taken and signed from the patient for publication.

### Authorship

All authors attest that they meet the current ICMJE criteria for Authorship.

### Author Contributions

**Srinu Deshidi:** Conceptualization, Data curation, Investigation, Writing – original draft

**Gaurav Mahajan:** Supervision, Writing – original draft, Writing – review & editing

**Vishwanath Kamisetty:** Investigation, Writing – original draft

**Spoorthi Kolla:** Investigation, Writing – original draft

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**Gongala Harshvardhan Reddy:** Investigation, Supervision, Writing – original draft, Writing – review & editing

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### Funding

No grant from a public, private or nonprofit organization.

### Conflicts of Interest

The authors declare no conflicts of interests.

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