Constipation as first sign of cancer: a silent end-stage malignancy – case report

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ABSTRACT

Background: New-onset constipation in middle-aged and older adults can be an early and sometimes the only presenting sign of colorectal malignancy. This risk is particularly relevant in populations with low screening uptake (e.g., in regions where national screening programs are recent or underutilized). Timely recognition of alarm features and appropriate imaging are important to diagnose obstruction and stage the disease.

Case presentation: A 54-year-old Saudi man without chronic illnesses presented with a 2-week history of progressive constipation and abdominal distension, and three days of diffuse abdominal pain with recurrent vomiting. He reported no flatus for 2 days and no stool for four days. He denied weight loss or rectal bleeding. Examination showed a markedly distended but soft abdomen with tenderness in the right lower quadrant; bowel sounds were hypoactive. The digital rectal exam was normal. Laboratory tests revealed leukocytosis (white blood cell count 11.4 × 10^9/l; reference range 4.5-11.0 × 10^9/l); renal function and electrolytes were normal. A supine abdominal radiograph demonstrated multiple dilated bowel loops with air-fluid levels and no distal colonic gas, consistent with large-bowel obstruction. Contrast-enhanced computed tomography identified a circumferential sigmoid mass (~3.7 × 3.0 cm) with an abrupt transition point and marked proximal colonic and small-bowel dilation. No mesenteric stranding, ascites, or free air was present; multiple hypodense liver lesions (largest ~2.5 cm) and enlarged iliac nodes indicated metastatic disease. No hernia was seen. Given the obstructive symptoms and stage IV disease, the patient underwent a palliative diverting colostomy. Postoperatively, he recovered uneventfully and was referred for oncology and palliative care.

Conclusion: New or worsening constipation in adults over 50 should prompt early evaluation for colorectal obstruction. Cross-sectional imaging is essential when obstruction is suspected, and management must be tailored to the disease stage. In metastatic cases, palliative decompression (e.g., stoma formation) can relieve symptoms and improve quality of life. Increased awareness of constipation as an alarm symptom and better colorectal cancer screening uptake are important to facilitate earlier diagnosis.

Keywords: Colon cancer, Constipation, Intestinal obstruction, Sigmoid mass, Metastases, Palliative stoma.

Type of Article: CASE REPORT **Specialty:** Emergency Medicine

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Introduction

Colorectal cancer (CRC) is a leading cause of cancer-related death worldwide and remains a major health burden in Saudi Arabia, where it is the most commonly diagnosed cancer in men and the third in women. Many cases are detected by screening, but a significant proportion still present symptomatically, sometimes at an advanced stage. New-onset or progressive constipation in adults ≥50 years – particularly when accompanied by abdominal pain, distension, or obstructive symptoms — should prompt early investigation to exclude an obstructing colonic lesion [1].

Why this case matters

While constipation is a common and usually benign complaint, this case illustrates three important teaching points: (1) progressive constipation may be the sole presenting symptom of advanced CRC in patients without weight loss or bleeding; (2) rapid progression to high-grade obstruction can occur even in otherwise healthy patients; and (3) prompt cross-sectional imaging enables appropriate palliative decision-making (diversion vs stent vs resection). These features make the case educational for clinicians working in settings with variable screening uptake.

Case Presentation

A 54-year-old Saudi man, previously healthy with no chronic medical conditions or prior abdominal surgery, presented to the emergency department with a 2-week history of progressive constipation and marked abdominal distension. Three days before the presentation, he developed diffuse abdominal pain and recurrent vomiting. He had not passed flatus for 2 days and had been stool-free for 4 days. There was no history of unintentional weight loss or rectal bleeding.

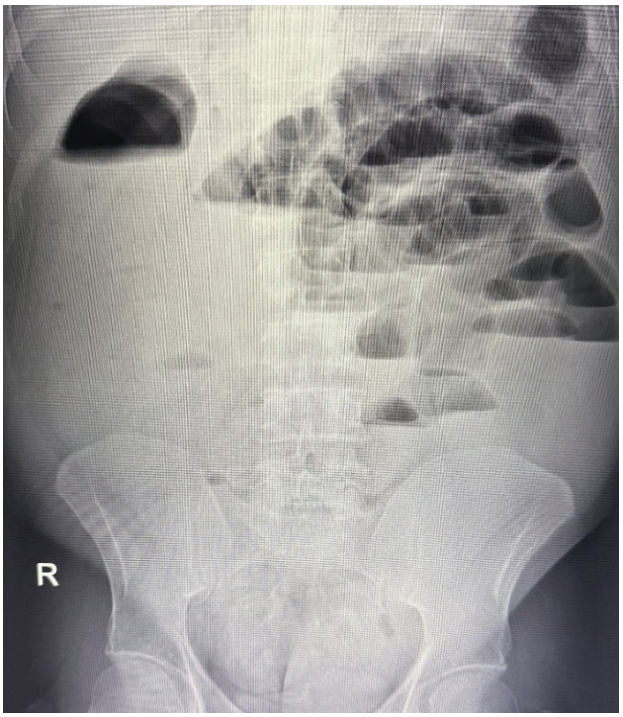

Figure 1. *Supine abdominal radiograph showing multiple dilated bowel loops and air-fluid levels with absence of distal colonic gas.*

On arrival, he was alert, afebrile, and hemodynamically stable. Physical examination revealed a markedly distended, soft abdomen with tenderness localized to the right lower quadrant. All hernial orifices were normal. Digital rectal examination did not reveal any masses or gross blood. Bowel sounds were hypoactive; there were no signs of peritonitis.

Laboratory tests showed leukocytosis (white blood cell count 11.4 × 10^9/l; reference range 4.5-11.0 × 10^9/l) with normal hemoglobin, renal function, and electrolytes. A preoperative serum carcinoembryonic antigen was not obtained in the acute setting. A supine abdominal radiograph demonstrated multiple dilated loops with air-fluid levels and no distal colonic gas, consistent with large-bowel obstruction (Figure 1).

Contrast-enhanced computed tomography (CT) of the abdomen and pelvis demonstrated circumferential concentric thickening of the sigmoid colon measuring approximately 3.7 × 3.0 cm at an abrupt luminal transition point in the mid-sigmoid, consistent with high-grade/

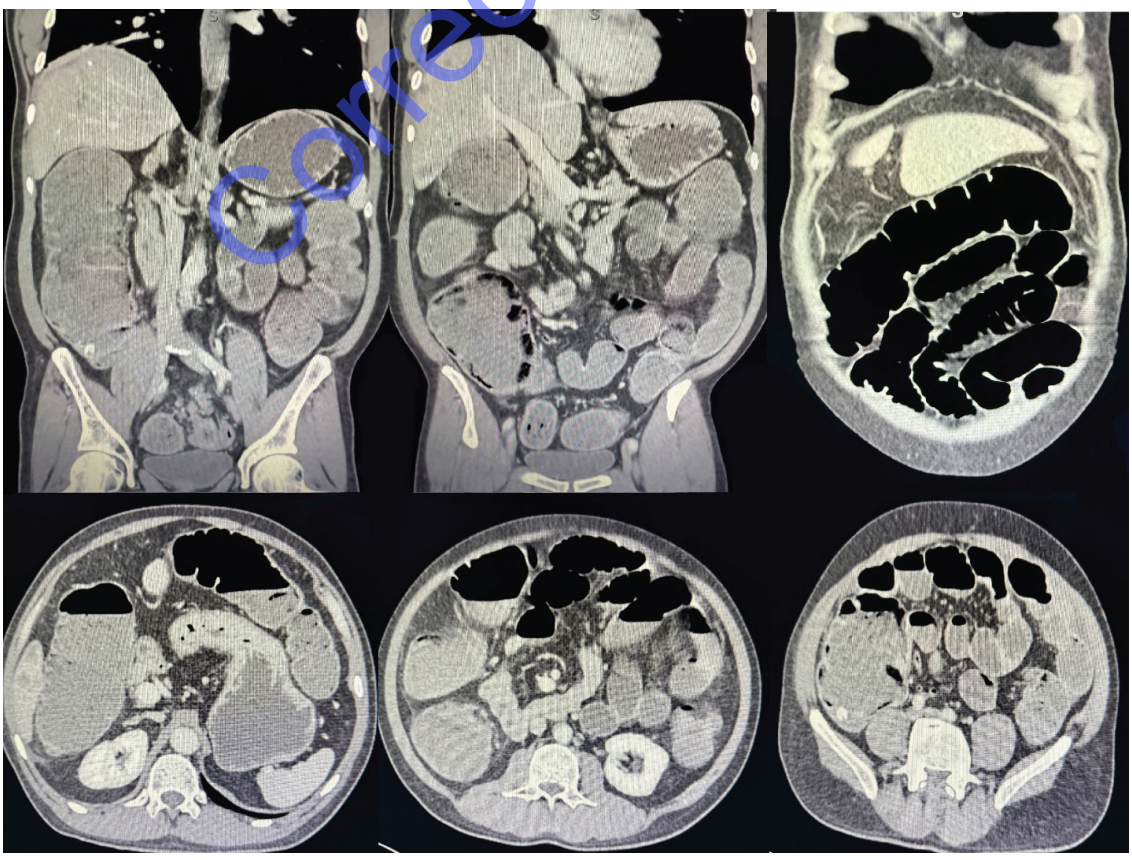

Figure 2. *Abdominal CT showing obstructive sigmoid mass with multiple hepatic lesions.*

near-complete large-bowel obstruction (Figure 2). There was preservation of pericolonic fat planes without mesenteric fat stranding, no ascites, and no free intraperitoneal air. Multiple hypodense hepatic lesions were seen in both lobes (the largest approximately 2.5 cm), highly suspicious for metastatic disease, together with enlarged left iliac lymph nodes (up to 1.9 × 1.7 cm). Radiologic staging based on CT, therefore, indicated locally advanced primary disease with nodal involvement and radiologic M1 disease.

In the ED, the patient received intravenous fluids and bowel rest. Given the obstructing lesion and CT evidence of metastatic disease, a palliative surgical approach was chosen. After resuscitation, he underwent urgent laparotomy and a diverting loop colostomy. Intraoperatively, a constricting sigmoid tumor was confirmed; there was no gross perforation or peritoneal carcinomatosis.

Postoperatively, the patient's recovery was uneventful. The colostomy began functioning on postoperative day (POD) 2; he passed flatus and tolerated clear fluids that day and advanced to a general diet by POD3. The stoma was viable with well-perfused mucosa, and there were no wound complications. He was discharged home on POD5 with arrangements for outpatient oncology and palliative care follow-up.

Discussion

This case highlights several important teaching points. Progressive constipation alone may be an early sign of advanced CRC, even without classic "red flag" symptoms such as weight loss or rectal bleeding. Our patient was otherwise healthy and reported no systemic symptoms — constipation and subsequent obstructive features were the sole presenting complaints — emphasizing that clinicians should investigate persistent or worsening bowel habit changes in middle-aged and older adults. Such presentations may be more common in settings with limited screening uptake; for example, national screening programs have been introduced only recently in some regions, which can delay diagnosis [1].

Epidemiologic evidence shows only a modest overall association between chronic constipation and CRC, but the probability of an underlying malignancy rises with older age and the presence of additional alarm features (abdominal distension, pain, vomiting, and obstipation) [2,3] In acute high-grade obstruction due to an intrinsic colonic lesion, patients can progress rapidly from altered bowel habit to complete or near-complete obstruction; timely imaging is therefore essential to confirm diagnosis and guide management [4,5].

Imaging in our patient provided both diagnostic localization and staging information. The plain abdominal radiograph supported the diagnosis of obstruction by showing multiple dilated loops and air-fluid levels with absent distal gas. Contrast-enhanced CT localized the lesion to the mid-sigmoid with an abrupt transition point and showed proximal dilation of the colon and small bowel, absence of mesenteric stranding or free air, and multiple hepatic lesions consistent with liver metastases. These CT features informed the decision to pursue palliation rather than immediate oncologic resection. The findings are consistent with tumor biology for sigmoid cancers (smaller lumen, higher likelihood of obstructive presentation) and hematogenous spread to the liver [6].

Management options for malignant large-bowel obstruction include endoscopic decompression with self-expanding metal stents (as a bridge to surgery or for palliation), primary oncologic resection (with or without stoma), diverting stoma, or bypass procedures. Stenting may be appropriate when technically feasible and when immediate oncologic resection is not planned; however, it requires endoscopic expertise and has associated risks, including perforation and migration. In patients with disseminated disease and an acute presentation, a diverting stoma can provide rapid symptom relief with lower immediate morbidity than major resection, which guided our decision in this case. This approach aligns with current practice recommendations for palliation in metastatic obstructing CRC [4,7].

Finally, the case underscores practical lessons for clinical care: maintain a low threshold for cross-sectional imaging when alarm symptoms accompany constipation; include stoma formation as a valid palliative option in multidisciplinary discussions; and advocate for screening programs to reduce the incidence of advanced presentations.

Conclusion

New-onset or progressive constipation in adults — particularly those over 50 or with accompanying alarm features (distension, pain, vomiting, or obstipation) — should trigger timely evaluation for colorectal pathology. Prompt history, careful physical examination, and early cross-sectional imaging facilitate diagnosis and staging and allow individualized treatment planning. When curative resection is not feasible, palliative decompression (such as stoma formation) is an effective option to relieve obstruction and improve patient comfort. This case highlights the continued importance of increasing screening uptake for earlier detection.

What is new

- New-onset constipation can be the first and only presenting symptom of advanced colorectal cancer, even without weight loss or rectal bleeding.
- Demonstrates successful symptom control with palliative diverting colostomy for obstructing metastatic sigmoid cancer.
- Reinforces the need for early imaging and expedited specialist referral when alarm features accompany constipation.

Conflict of interest

The authors declare no conflicts of interest.

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Author contributions

All authors contributed equally to manuscript drafting and approved the final manuscript.

Consent for publication

Written informed consent for publication (including images and clinical details) was obtained from the patient.

Ethical approval

Ethical approval is not required at our institution to publish an anonymous case report.

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Summary of the case

Item	Details
Age/sex	54-year-old male
Presentation	A 2-week history of progressive constipation and abdominal distension; 3 days of diffuse pain and vomiting; obstipation
Key findings	X-ray: multiple air-fluid levels; CT: obstructing sigmoid mass (~3.7 × 3.0 cm) with proximal dilation; multiple liver lesions (largest ~2.5 cm); enlarged iliac nodes
Management	Urgent diverting colostomy (palliative); oncology and palliative care referral
Outcome	Colostomy functioning by POD2; advanced to general diet POD3; discharged POD5; outpatient oncology follow-up arranged