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## Clinical Communications: Adults

### INTESTINAL PERFORATION AFTER THE INCIDENTAL INGESTION OF A FISHHOOK

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□ **Abstract**—The vast majority (75%) of ingested foreign bodies pass through the gastrointestinal tract spontaneously and require no surgical intervention. Indeed, the emergency department (ED) management of ingested foreign bodies is largely based on the age of the patient and the time elapsed since ingestion, as well as the physical characteristics of the foreign body. We present this case to emphasize the importance of radiologic imaging studies in the ED management of adults with an acute abdomen of unknown etiology. A 44-year-old woman presented to the ED with right upper quadrant pain of 2 days duration. There was evidence of localized peritoneal irritation on physical examination. A radio-opaque fishhook-shaped object was visualized on the plain abdominal film. Helical computed tomography demonstrated a metallic object in the small bowel with extension through the thickened and inflamed intestinal wall. The patient did not report known ingestion of a foreign body. At exploratory laparotomy, a fishhook was recovered despite the patient's unawareness of having ingested a foreign body. The ED management of an otherwise healthy adult with an acute abdomen was facilitated with plain film radiography and abdominal computed tomography. © 2010 Elsevier Inc.

□ **Keywords**—intestinal perforation; fishhook; foreign body; computed tomography

#### INTRODUCTION

Approximately 75% of ingested foreign bodies pass spontaneously through the gastrointestinal tract with-

out complication and can thus be managed expectantly (1). Exceptions to expectant management include the ingestion of disk batteries, which have the potential for leakage of alkali and heavy metals, foreign bodies lodged in the esophagus, foreign bodies that elicit symptoms, foreign bodies that do not spontaneously progress through the gastrointestinal tract, and foreign bodies that exceed a specific size, depending on the patient's age (1–4). Adding to the difficulty in managing such patients, however, is the situation in which the ingestion of a foreign body is unknown and the diagnosis is delayed or elusive.

Although intestinal perforation by a foreign body is uncommon, when perforation occurs, anatomic areas of acute angulation or physiologic narrowing, such as the ileocecal valve, are most often involved (1,5). The risk of perforation is increased in the case of thin, pointed objects, and also may be higher in patients with adhesions secondary to abdominal surgery (1,6).

We report a case of a patient who unknowingly swallowed a fishhook that ultimately perforated the small bowel.

#### CASE REPORT

A 44-year-old woman was admitted to the Emergency Department (ED) due to the sudden onset of severe right



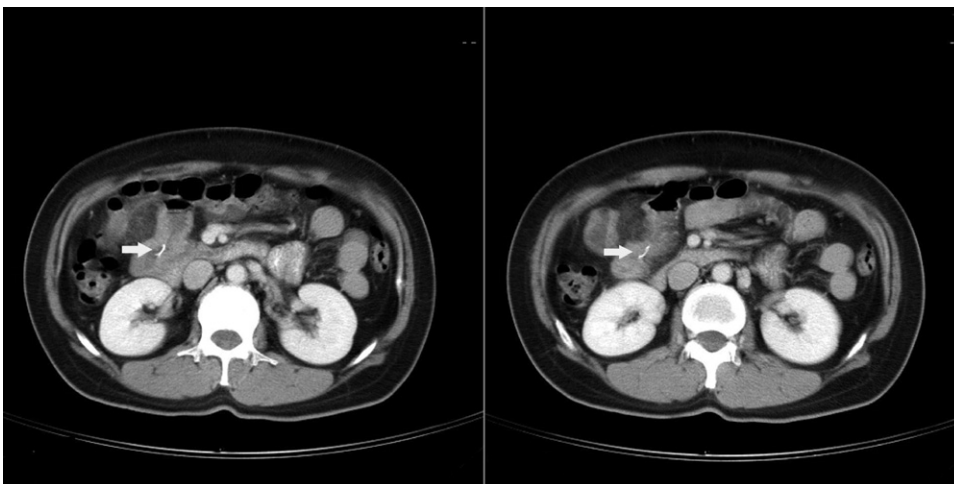
**Figure 1.** On plain radiography, the arrow points to a fishhook-shaped foreign body.

upper quadrant abdominal pain of 2 days duration. She had experienced intermittent abdominal pain several weeks before admission, but did not seek medical attention. The pain was cramping in nature, primarily located in the periumbilical area, and intermittently associated with diarrhea. There were no associated fevers, chills, nausea, vomiting, or tarry stools. She did not have a history of medical or psychiatric illnesses.

Physical examination revealed a non-distended abdomen with normal bowel sounds, but with marked tenderness to palpation and no guarding in the right upper quadrant. The complete blood count revealed 14,360/mL white blood cells with 79.3% neutrophils and 12.6% lymphocytes, hemoglobin of 11.9 g/dL, and 393,000/mL platelets. Urinalysis and blood chemistries, including renal and liver profiles, were normal. A plain abdominal radiograph revealed a foreign body, suspicious for a fishhook, in the mid-abdomen without obvious pneumoperitoneum (Figure 1). The patient was questioned further and denied intentional or inadvertent foreign body ingestion, but noted the recent ingestion of fish. Abdominal computed tomography (CT) scan showed a metallic foreign body lodged in the jejunum, extending through the intestinal wall, and associated with segmental annular wall thickening and a surrounding fat desmoplastic reaction due to the peritonitis. No extraluminal air or contrast media was seen (Figure 2). An emergency laparotomy revealed a small intestinal perforation, 200 cm distal to the ligament of Treitz. She underwent segmental resection of the small bowel with an end-to-end anastomosis. The surgical specimen showed a linear ulcer measuring 1 cm in length with perforation. A fishhook, 1.5 cm in length, was present at the site of perforation, connected to a small piece of fishing line (Figure 3). The patient made an uneventful recovery and was discharged on the tenth post-operative day.

## DISCUSSION

The majority of ingested foreign bodies pass through the gastrointestinal tract uneventfully (1,2,7,8). The management of ingested foreign bodies is determined not only



**Figure 2.** CT scan revealed a metallic foreign body (arrow) in the lumen of the small intestine with extension through the thickened and inflamed wall, suggestive of perforation.

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