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CLINICAL CASE

Colonic gallstone ileus: A rare cause of intestinal obstruction☆

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KEYWORDS
Obstruction;
Gallstone ileus;
Gallstone;
Cholelithiasis;
Cholecystitis

Abstract
Background: A gallstone colonic ileus is a very rare condition.
Clinical case: The case is reported of an 87 year-old patient who came to the Emergency Department due to an intestinal obstruction of several days onset, which was caused by a gallstone affected sigmoid colon.
Conclusion: Colonic gallstone ileus is a rare disease that usually occurs in older patients due to the passage of large gallstone directly from the gallbladder to colon, through a cholecystocolonic fistula. It has a high morbidity and mortality.

PALABRAS CLAVE
Obstrucción;
Íleo biliar;
Cálculo biliar;
Colelitiasis;
Colecistitis

Íleo biliar colónico: una rara causa de obstrucción intestinal

Resumen
Antecedentes: La obstrucción intestinal en colon, como consecuencia de un cálculo biliar, es una enfermedad extremadamente rara, que suele desarrollarse en muy pocas ocasiones.
Caso clínico: Presentamos el caso de una paciente de 87 años, que acude al servicio de urgencias por cuadro compatible con obstrucción intestinal de varios días de evolución, como consecuencia de un cálculo impactado en colon sigmoide.

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Conclusión: El íleo biliar colónico es una enfermedad muy rara, que ocurre generalmente en pacientes de edad avanzada, como consecuencia del paso del cálculo de gran tamaño desde la vesícula al colon, a través de una fístula colecisto-cólica, siendo una enfermedad con una elevada morbimortalidad.

Background

Intestinal obstruction caused by a gallstone trapped in the colon is an extremely rare entity,[1] which usually occurs due to the passage of a large stone through a cholecystocolonic fistula.

Objective

We present the case of a gallstone ileus at the level of the sigmoid colon.

Clinical case

An 87-year-old woman with a history of systemic high blood pressure, osteoporosis, polyarthritis, and polymyalgia rheumatica attended the emergency department with abdominal pain associated with vomiting and constipation of 3 days onset.

On examination the patient was in an acceptable state of general health, afebrile and haemodynamically stable; with a distended abdomen tympanic on percussion, generally painful but with no signs of peritoneal irritation on palpation, no hernia defects were identified. A minimal amount of faeces was found on rectal examination.

Laboratory tests were requested in the emergency department which revealed elevated C reactive protein, and all the other parameters were within normal limits. Plain abdominal X-ray showed signs compatible with intestinal obstruction at the level of the descending colon. Because a mechanical intestinal obstruction was suspected, computed axial tomography (CAT scan) was requested to confirm the cause of the obstruction, which revealed marked dilatation of the entire colon up to the sigmoid colon, and showing an image of 5 cm entirely occupying the lumen. Likewise, aerobilia was identified predominating in the left liver lobe, gas in the cystic duct and the bile duct; a collapsed gallbladder with gas in its interior, adjacent to the hepatic flexure of the colon. All of which were findings compatible with gallstone ileus at the level of the sigmoid colon (Fig. 1A and B).

Due to the clinical picture and the progressive increase in laboratory study levels, and the clinical deterioration of the patient, with pain and abdominal distension increasing since her admission, emergency surgical intervention was decided. An exploratory laparotomy was performed which identified marked dilatation of the colic structure, with apparent calibre changes at the level of the sigmoid colon, where the impacted gallstone was palpated. The gallstone was disimpacted, and moved proximally towards the transverse colon, where a colotomy was performed, the gallstone was removed and then a simple closure of same was performed (Fig. 2A and B). No surgical manoeuvres were performed on the gallbladder or the cholecystocolonic fistula.

The patient developed acute respiratory failure in the immediate postoperative period, which evolved favourably until diuresis and creatinine levels normalised, atrial fibrillation was identified with slow ventricular response, de novo, and acute confusional syndrome. The patient also presented a deep surgical wound infection which lengthened her stay in our department for daily dressings. She was discharged home on the 20th postoperative day.

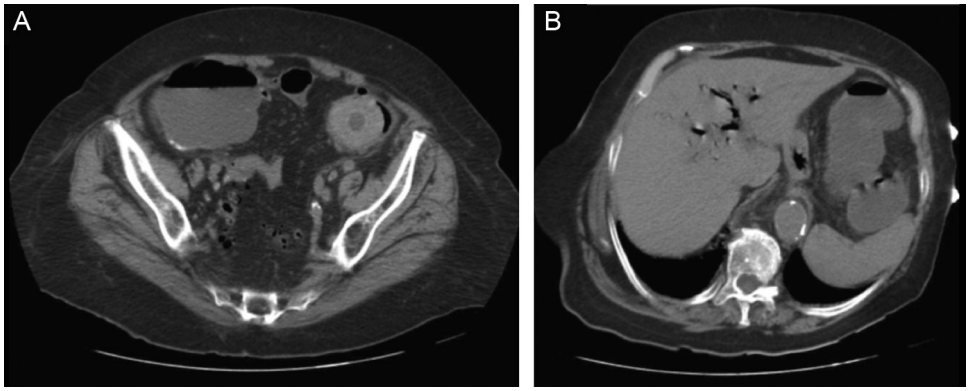

Figure 1 (A, B) CAT scan image with stone impacted in the sigmoid colon and aerobilia.