BMJ Case Reports

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Sigmoid gallstone ileus: a rare cause of large bowel obstruction

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DESCRIPTION

A 91-year-old woman presented with abdominal distension and pain. She had not vomited and opened her bowels only with scanty stool. On examination she was tachycardic with a distended abdomen with left-sided tenderness. On admission her C reactive protein was 77 mg/l, white cell count of 9.9×10^{9}l and normal liver function tests. Abdominal plain films revealed dilated large bowel. Subsequent CT scan showed aerobilila and a large 4.6 cm gallstone lodged in the sigmoid colon (figure 1). An attempt at removal by flexible sigmoidoscopy failed. She underwent a limited laparotomy where a successful enterolithotomy was performed (figure 2). She made an uneventful recovery and remains well on 3-months' follow-up.

Gallstone ileus causing obstruction of the sigmoid colon is rare. A cholecystocolonic fistula is the usual mechanism for passage of a large gallstone capable of obstruction into the colon. Of the few cases of sigmoid gallstone ileus in the literature, conservative, endoscopic and surgical management have been advocated.[1] Endoscopic management includes snaring the stone or using a lithotripter to break up the stone. Surgical options include enterolithotomy (laparoscopic or open)[2] or single-stage enterolithotomy with cholecystectomy and fistulectomy with cholangiography if deemed necessary. The latter is technically difficult and should be reserved for low-risk patients.[3] In the higher-risk population, we advocate an initial attempt at endoscopic

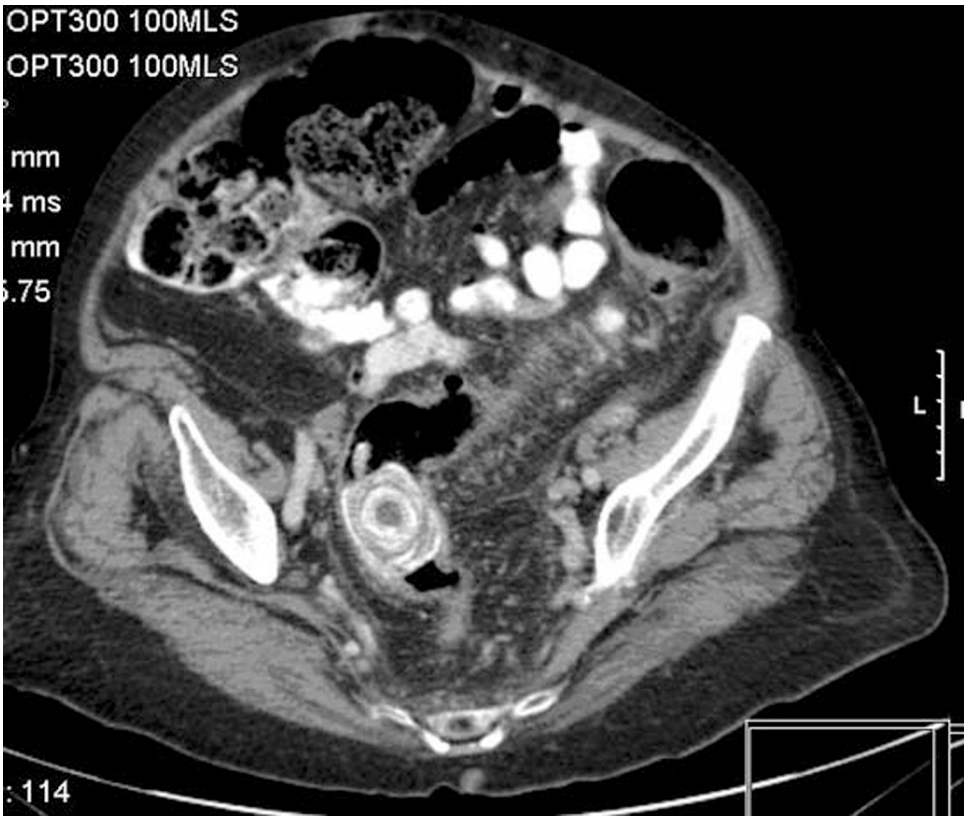

Figure 1 CT scan showing a 4.6 cm gallstone in sigmoid.

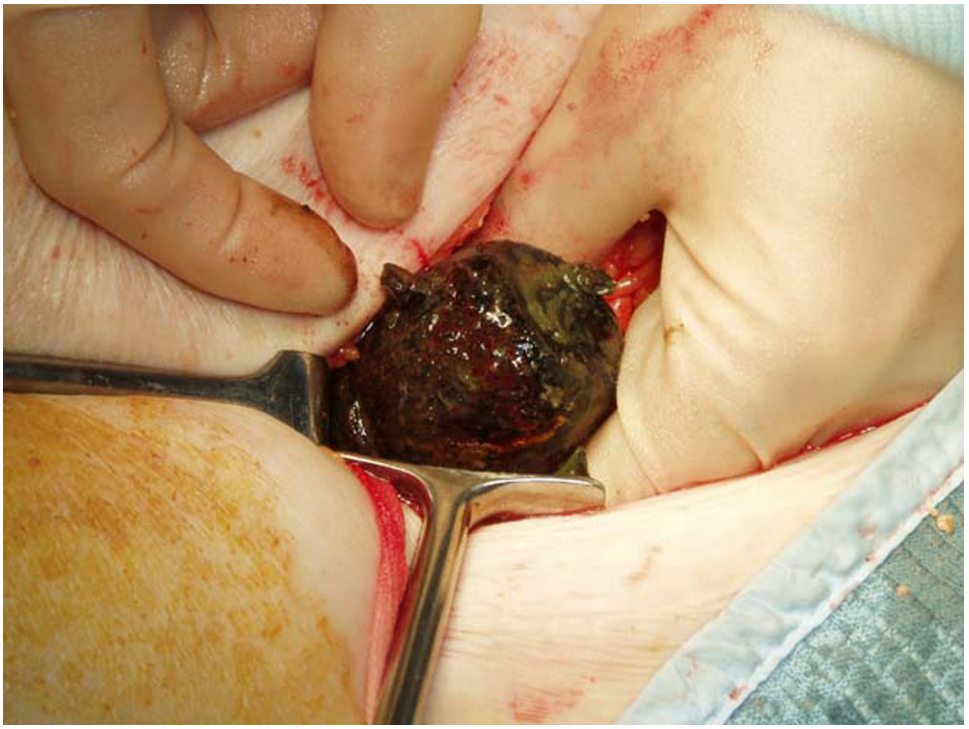

Figure 2 Open enterolithotomy.

removal, which if fails could then be followed-up with an open enterolithotomy. An interval fistulectomy and cholecystectomy could then be performed depending upon patient fitness and choice.

Competing interests None.

Patient consent Obtained.

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