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 aerobililia 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...
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.

REFERENCES

Figure 2  Open enterolithotomy.