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Unusual cause of small bowel obstruction in an autistic child

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DESCRIPTION

A 10-year-old girl with a background of global developmental delay and autism was admitted to our hospital with vomiting for 10 days. She had not opened her bowels for 5 days. Owing to her developmental delay she was unable to communicate verbally. Examination was unremarkable, including her abdomen which was soft with no distension and no masses felt. Her routine blood tests including full blood count, urea, creatinine, electrolytes, liver function tests and amylase levels were in the normal range. C-reactive protein (CRP) was less than 5. Blood cultures and urine cultures showed no growth. She was clinically diagnosed as a viral gastritis and started on intravenous fluids and ranitidine.

Two days after her admission, her vomiting was noted to be bilious and she had an abdominal x-ray (figure 1), abdominal ultrasound scan and paediatric surgical review.

The ultrasound scan demonstrated gross faecal loading and her presentation was now attributed to constipation. On laxative treatment she was opening bowels daily.

However, she persisted with intermittent bilious vomiting. The abdominal examination again revealed soft non-distended abdomen with normal bowel sounds. Initial digital rectal examination on day 3 of admission showed no significant abnormalities. As she was opening bowels regularly with no abdominal distension and normal bowel sounds, the paediatric surgical team did not consider bowel obstruction as the cause for her bilious vomiting.

However, 9 days after her admission, in view of the persistence of intermittent bile-stained vomiting, the patient had a CT scan of the abdomen (figure 2) that revealed a distal small bowel obstruction secondary to a Bezoar. On further questioning the patient's mother revealed that she often had a tendency to swallow non-edible objects. The patient underwent a laparotomy which revealed a partial distal small bowel obstruction due to a whole rubber glove. She made a good recovery and was discharged home 2 days postoperatively. This is an unusual clinical presentation of subacute partial small intestinal obstruction. The diagnosis was delayed as she had no classical signs of intestinal obstruction except for intermittent bile-stained vomiting.

Although ingestion of foreign bodies is relatively common in developmentally delayed and autistic children, they do not present with intestinal obstruction due to the small size of the ingested objects. In most cases the

Figure 1 Abdominal radiograph demonstrating dilated small bowel with mucosal oedema in the right iliac fossa.

Figure 2 Abdominal CT scan demonstrating distal small bowel obstruction secondary to a bezoar.

ingested objects are passed in stools with some patients requiring endoscopic removal depending on the location of the foreign object. Small bowel obstruction secondary to a Bezoar is rare but it is important to elicit a history of pica in children who are potentially at risk, for example those who are developmentally delayed and autistic children.¹⁻³

Ingestion of whole rubber glove as the cause for small bowel obstruction in autistic children has been rarely reported. This case highlights that in children presenting with bilious vomiting, a surgical cause must be sought and ruled out.

Contributors All the authors have contributed in patient management.

Competing interests None.

Patient consent Obtained.

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