

Enterolithiasis: A Rare Case Report

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1. Introduction

Enterolithiasis correspond to the presence of stone concretions in the gastrointestinal tract. Primary enteroliths arise in areas of intestinal stasis, such as in the setting of diverticular disease, surgical entero - anastomosis, blind pouches and intestinal stenosis or strictures seen in infectious or inflammatory bowel diseases. Presentation is often nonspecific but typically includes "colicky" abdominal pain, nausea, vomiting other symptoms related to the bowel obstruction.

2. Case Summary

A 46 - year - old female presented to the causality with history of progressive lower abdominal pain for 12 days associated with nausea, vomiting, decreased frequency of flatus and non - passage of stools for 5 days. Patient had similar complaints 11 months ago for which she was

diagnosed with symptomatic cholelithiasis. On examination abdomen was doughy, mildly distended and diffuse tenderness was present with sluggish bowel sounds. On Per rectal Examination Fecoliths were present.

Abdominal contrast - enhanced CT scan was suggestive of dilation of jejunal, proximal and mid ileal loops measuring upto 3.8 cm in antero - posterior diameter. There was a focal wall thickening of the mid and distal ileal loop measuring upto 9 mm in width and extending for a length of upto 4 cm with a small defect (2.8 mm) in the anterior wall and at this level with extravasation of contrast into the peritoneal cavity suggestive of perforation. A well - defined oval - shaped hyper dense intraluminal structure (fig 1) (860HU) was seen in distal ileum at the perforation site causing near complete obstruction of the lumen. A 13.5 cm x 6.4 cm in cross section intraperitoneal fluid collection with extravasated contrast with air fluid levels was located anteriorly in the lower abdomen towards right side.

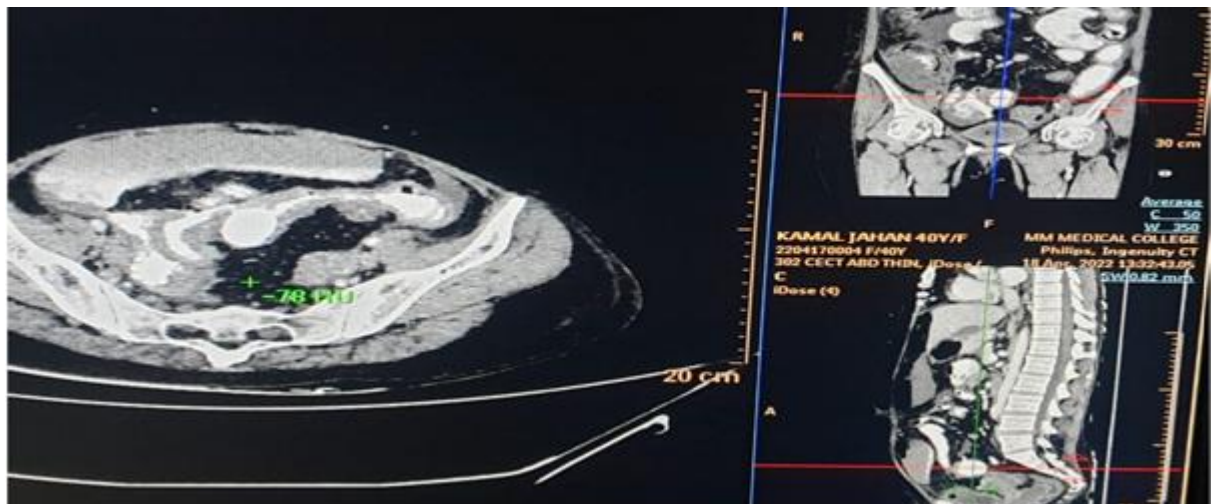


Figure 1

3. Procedure

Exploratory laparotomy was done after correlating clinical and radiological findings. Intraoperative findings: About 2 litre of biliopurulent fluid drained from peritoneal cavity. Perforation of distal ileum (fig2) of size 2x1.5cm located 20cm proximal to ileocecal junction with localised pregangrenous changes. A 3x2.5cm single impacted stone (fig 3 & 4) located in ileum just distal to the perforation site and was removed. Resection and anastomosis with divided ileostomy was done. The postoperative period was uneventful. Biochemistry examination of stone was done suggestive of oxalate stone. After ruling out every possible causes enterolithiasis, it was termed idiopathic.



Figure 2

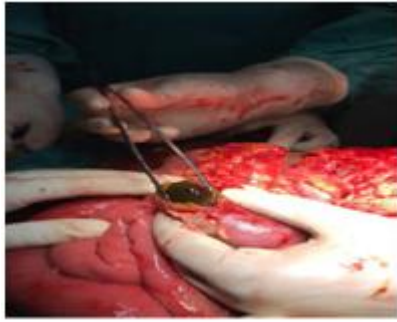


Figure 3



Figure 4

4. Discussion

True primary enteroliths are formed from substances found in chyme under normal alimentary conditions. Divided into choleicacidenterolithiasis and calcium salt enterolithiasis. Choleicacid enteroliths requires lower pH typically found in the proximal small bowel while calcium salt enteroliths require an alkaline pH formed in the terminal ileum. False primary enteroliths are formed from insoluble foreign substances in the bowel, secondary to exogenous particle ingestion such as bezoars. Mixed concretions may result from external calcification of false enteroliths in the distal small bowel.

5. Conclusion

In the setting of SBO, enterolithiasis a rare and uncommon medical condition that may fall out of the surgeon's etiological scope. This clinical and radiological entity should be within the diagnostic and therapeutic preview of the general surgeon, radiologist and gastroenterologist when assessing patients with SBO. Clinician's awareness of enterolithiasis as a cause of SBO may yield timely etiologic recognition, treatment and correction of risk factors for the development and recurrence of stones, thus decreasing morbidity mortality associated with this pathology.