

Partial Small Bowel Obstruction Secondary to Intestinal Stone (Enterolith): A Very Rare Case Report

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Introduction

Enterolithiasis is an uncommon pathological condition in which calculi or concretion formation occurs in the intestines and has a prevalence ranging from 0.3 to 10%.¹ The mortality rate for uncomplicated primary enterolithiasis is very low, but it rises to 3% in poorly conditioned patients with significant obstruction and a late diagnosis. Primary enteroliths arise in areas of intestinal stasis in the setting of diverticular disease, surgical enteroanastomosis, blind pouches, and intestinal stenosis or strictures seen in the infectious or inflammatory bowel diseases. Secondary enteroliths include gallbladder and renal stones that may migrate into the gastrointestinal tract as a result of fistula formation. Enteroliths can cause bowel obstruction, If .haemorrhage, or perforation, but the vast majority are cleared asymptotically Treatment .nonoperative therapeutic management fails, surgical exploration is indicated.² relies on timely recognition of the disease and endoscopic or surgical intervention. With .advants in new technology, improved outcome is expected for patients with enterolithiasis 3 abdominal pain, nausea, ”tumbling“Presentation is often nonspecific, but typically includes and vomiting related to the bowel obstruction, and may potentially lead to the gastrointestinal bleeding and perforation. We present a case of primary enterolith in 7 year old boy resulting in symptoms of partial small bowel obstruction and highlight the rarity of condition

Case presentation

old boy was previously healthy with no significant surgical or medical -year-We present 7 history, who visited our private clinic for workup of lower abdominal pain and vomiting. On examination he was vitally stable with RIF tenderness. A primary suspected diagnosis of appendicitis was made. An abdominal ultrasound (US) showed mild free fluid. Initial laboratory findings showed an elevated white blood cells (WBC). The decision was made to proceed with a laparoscopic appendectomy, and the patient was prepared for surgery. Upon entry into the peritoneal cavity, the appendix looking mildly inflamed, appendectomy was luminal -done. Further inspection of small bowel for a second pathology revealed an intra mass at the the proximal jejunum with features of partial small bowel obstruction. The decision was made to convert to laparotomy (Figure 1). After the bowels were eviscerated from the mesenteric -wound, a large, hard, sliding mass was found (Figure 2). A longitudinal anti enterotomy was performed and the large stone (50*30 mm) was extracted (Figure 3). The and closed in layers in a enterotomy was closed transversely. The abdomen was irrigated

standard fashion. The patient made good recovery and discharged 3 days after surgery with no complications. Analysis of the biochemical composition of the intestinal stone showed the presence of calcium oxalate stone (Figure 4)



Figure (1): Upper midline laparotomy incision



Figure 2: Hard intraluminal mass



Figure 3: Intestinal stone (50X30) mm

Description of stone			
Weight:	14.60 g	Size:	Multi Pieces
Color:	Brown	Consistency:	Solid
Surface:	Soft	Shape:	Irregular
Chemical			
CARBONATE (CO ₃ -2)...	(+)	CYSTINE	Negative
PHOSPHATE (PO ₄ -3)...	Negative	MAGNESIUM	Negative
CALCIUM (Ca+2)	(++)	AMMONIA	Negative
URIC ACID	Negative	OXALATE (C ₂ O ₄ -2) ..	(+)
Conclusion : Calcium&oxalate Stone			

Figure 4: Biochemical analysis shows Calcium Oxalate stone

References

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