Case Report

An Unusual Case of Small Bowel Obstruction

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Abstract

Small bowel obstruction is a general surgical emergency usually caused by adhesions or herniae. Malignancy, inflammatory bowel disease and ingested foreign bodies (bezoars) are rarer causes. Bezoars can occur at any point in the gastrointestinal tract (GIT) depending on the type of bezoar and the point of impaction. Abdominal CT scan can assist in making an accurate and timely diagnosis of bezoar-induced small bowel obstruction. Bezoar-induced acute bowel obstruction requires either endoscopic or surgical extraction to avoid the complications of hemorrhage, perforation or fistula formation.

Keywords: Small bowel obstruction; Bezoar; Phytobezoar

Introduction

Acute small bowel obstruction is a common general surgical emergency usually resulting from adhesions or herniae. Bowel obstruction in a virgin abdomen is uncommon, with the main causes being malignancy, inflammatory bowel disease or ingested foreign bodies [1]. Ingested foreign bodies may be food or non-edible objects. Incidents of ingesting non-edible objects occur in children, elderly patients, psychiatric patients, prisoners and intoxicated individuals [2]. Bowel obstruction from edible items may occur in those with gastrointestinal motility disorders, Guillain-Barre syndrome, hypothyroidism and fast eaters [3]. Food items that have been reported to cause obstruction include dried fruit, apricot, coconut, raw banana and a whole lemon [3-5]. We report a case of acute small bowel obstruction requiring operative intervention in a 59-year-old lady caused by undigested vegetable.

Case Report

A 59-year-old lady was admitted via the emergency department with a 12 h history of colicky lower abdominal pain, bilious vomiting, constipation and abdominal distension. The patient had no history of previous surgery, Crohn’s disease or diverticulosis. She took no regular medications, and had no family history of bowel pathology. Systematic review was unremarkable. Observations revealed a pulse rate of 95 bpm and a temperature of 37.8 °C. On examination the patient had no evidence of recent weight loss, pallor or jaundice. On examination the abdomen was markedly distended, and there were no surgical scars and no abdominal wall or groin herniae. Palpation demonstrated a soft abdomen, with minimal tenderness in the right iliac fossa (RIF), percussion demonstrated a hyper-resonant abdomen and no bowel sounds were elicited on auscultation. PR examination was unremarkable. Admission bloods were notable only for an elevated white cell count (WCC) of 12.5 × 10⁹/L, hemoglobin, renal function, liver function, lactate and C-reactive protein were all normal. Plain film of the abdomen (PFA) showed dilated loops of small bowel with no air in the rectum (Fig. 1).

Figure 1. PFA demonstrating dilated small bowel loops and no air in the rectum.
Small bowel obstruction due to bezoar is relatively uncommon. A high index of clinical suspicion must be present, as symptoms and signs are variable depending on the type of bezoar and the point of impaction. Abdominal CT scan can lead to a more accurate and timely diagnosis, and early surgery is advocated for bezoar-induced small bowel obstruction to reduce the rate of complications such as hemorrhage, perforation or fistula formation.

Acknowledgement

We would like to acknowledge the assistance of Mr. D. Gilpin.
Consultant Surgeon, Daisy Hill Hospital for his invaluable contribution to this case report.

**Grant**

None.

**Conflict of Interest**

We have no conflicts of interest to declare.

**References**