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IMAGE ARTICLE

Clinical Image: Gallstone Ileus

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A 90-year-old lady with dementia, coronary artery disease, and hypertension and no prior abdominal surgeries presented with three days of nausea/vomiting. She had normal vitals and generalized abdominal tenderness. Labs were unremarkable. CT (abdomen/pelvis) demonstrated a distal small bowel obstruction with pelvic transition point (Figure 1A) and hypodense lesions in segment 5 and adjacent to the caudate lobe. MRI (ab-

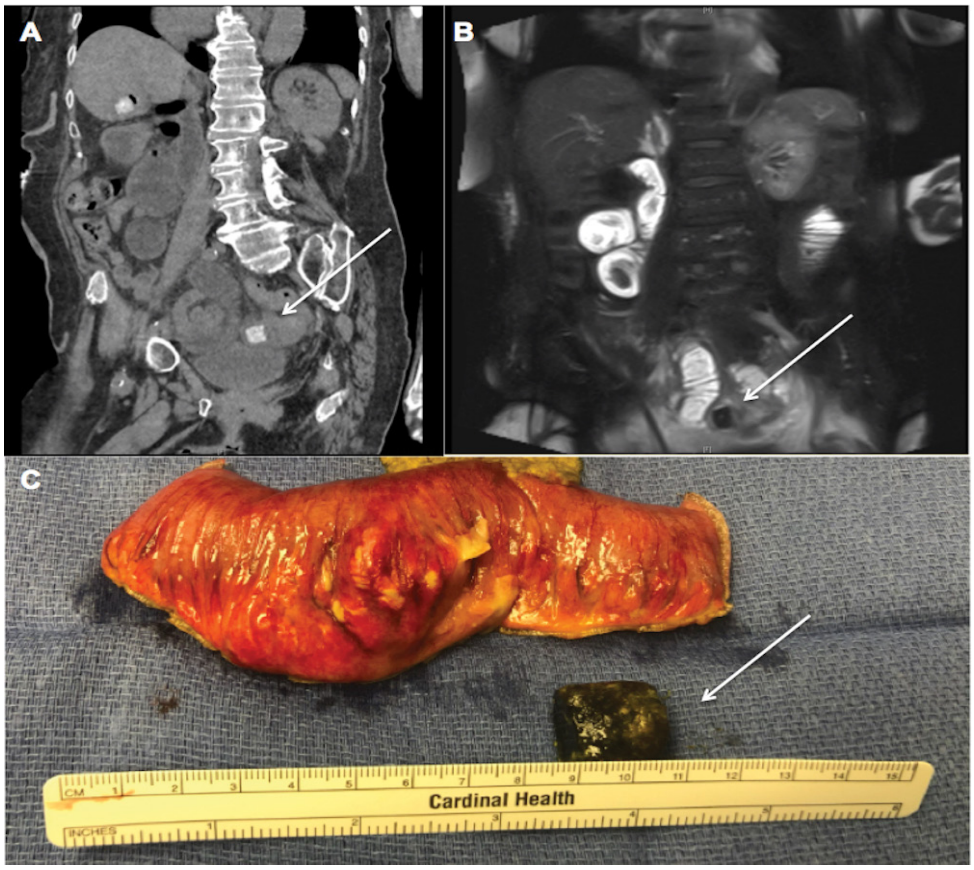

Figure 1: CT scan (A) MRI; (B) of the abdomen and pelvis demonstrates intra luminal gallstone in the distal jejunum with resultant small bowel obstruction. At surgery, a 2 cm obstructing gallstone was noted in the distal jejunum; (C) small bowel resection was performed secondary to perforation at the site of stone impaction.

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domen) demonstrated cholecystoduodenal fistula and obstructing gallstone in the distal jejunum (Figure 1B). She underwent diagnostic laparoscopy, revealing distal jejunal obstruction secondary to impacted gallstone with associated necrosis/perforation. She underwent laparoscopic small bowel resection (Figure 1C). The patient was discharged on postoperative day 8 without issues. Gallstone ileus is a rare cause of small bowel obstruction, often affecting the elderly with an estimated mortality up to 30%. Presentation is often nonspecific which often contributes to delayed diagnosis. In the acute setting, cholecystoduodenal fistula takedown is generally not required. This should be reserved for patients that are younger, have recurrent gallstone ileus, or if there is a concern for malignancy. When no perforation is present, simple enterotomy with removal of the obstructing gallstone is the generally recommended treatment. It is important to examine the remainder of the small bowel no ensure no other intestinal gallstones are present.