Intermittent small bowel obstruction secondary to enterolithiasis in Crohn’s disease

**Key words:** Crohn’s disease. Intestinal obstruction. Stenosis.

**Case report**

Man of 43 years-old, with no toxic habits, cardiovascular risk factors or previous surgery. He was diagnosed of Crohn's disease 11 years ago localized in ileum and colon, in treatment with mesalazine. Among the tests that were performed along the course of his disease there were two intestinal transits with barium and two colonoscopies. He came to the Emergency Unit for epigastric pain of one month of evolution, becoming continuous and more intense in the last 48 hours, accompanied of abdominal distension, nausea, vomits and constipation. To the physical examination he showed a good general condition, no fever and hemodinamic stability, with a distended abdomen, tympanic, painful to the diffuse palpation and decrease in intestinal peristalsis. Among the complementaries studies there were a hemogram and a general analysis with acute phase reac-

**Discussion**

We know as enterolithes the calculations made by the deposition of mineral salts in concentric layers around a core, usually constituted by non-digestible organic matter. It is a common disease in some animals such as horses, but not in humans. Among the factors involved for their formation is the existence...
of diverticula, adhesions, narrow segments along the digestive tract, previous examinations with barium and slowed intestinal transit (1-6). The latter is postulated as the main factor in its formation, and in most cases before enterolithiasis there is a long history of IBD. (1,2). These cases, according to some authors should consider us the possibility of an underlying adenocarcinoma (1). They are usually asymptomatic and they are found as an accidental discovery in a test image. Finding suggestive images lithiasis outside their areas, such as kidney or gallbladder, should make us suspect that we are facing an enterolithiasis (2). When the disease is symptomatic it can present as a chronic anemia by digestive bleeding, obstruction, pseudoobstruction, intestinal perforation among others (3).

Most enterolithes are radiopaque, easily visible with a simple test of radiology. But we can not discard them with a normal X-ray because some of them are radiolucent (made of magnesium salts). In these cases the study should be completed with CT scan (4,5).

In our patient we find some of those factors reflected in the literature as predisposing to the formation of enterolithes such as long evolution of Crohn’s disease, radiological studies with barium and stenosis along the intestinal tract.

Sometimes it is possible the resolution of the case by endoscopic balloon dilation, allowing the stone extraction by endoscopy. This technique is described like a choice in most cases because good results and low complication rate (< 5%). In those cases in which it is not possible, we can conduct the resection of the bowel affected by laparotomy or laparoscopy (6), as in our case.

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References


Fig. 2. Limestone formations.