Large bowel obstruction due to gallstone: ‘gallstone coleus’

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Abstract

We report the case of an 82-year-old lady who presented with large bowel obstruction. The computed tomography scan revealed an obstructing gallstone in the sigmoid colon. At colonoscopy the stone was seen in the sigmoid colon proximal to a diverticular stricture. After balloon dilatation of the stricture under general anaesthesia, the stone was removed. This approach should be the treatment of choice; only if this fails should surgical treatment be considered.

Keywords

Colonic gallstone ileus; large bowel obstruction.

Case report

A fit 82-year-old lady presented with a 6-day history of colicky abdominal pain and constipation. She was passing flatus. There were no urinary symptoms. Two years earlier she was admitted with *Staphylococcus aureus* septicaemia due to acute cholecystitis but had no previous abdominal surgery. Her past medical history included hypertension. On examination, her vital signs were normal. The abdomen was distended, with generalised tenderness but no peritonism. Bowel sounds were normal. The white cell count was 11,500/mm³. Serum amylase and liver function tests were normal.

A plain abdominal film showed large bowel dilatation to the distal sigmoid colon. Abdominal ultrasound revealed gas in the biliary tree, but no stones in the gall bladder and a common bile duct measurement of 1.3 cm (Fig. 1). On computed tomography (CT) scan there was large bowel obstruction due to a 6 × 4 cm gallstone in the sigmoid colon (Fig. 2).

At colonoscopy the stone was seen in the sigmoid colon proximal to a diverticular stricture. After balloon dilatation of the stricture under general anaesthesia the stone was removed (Fig. 3). No surgery was required and she has remained symptomless. No cholecystocolic fistula was seen on barium enema.

Discussion

Large bowel obstruction due to an impacted gallstone (gallstone coleus) is rare[1]. The sigmoid colon is the most common site of obstruction usually due to a diverticular stricture[1].

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It usually occurs in the elderly, is six times more common in women than men and is associated with a high rate of mortality (12–18%)\(^2\). Impaction of the stone in the colon is rare probably because stones that are small enough to pass through the ileocaecal valve pass through the rectum as well\(^3\).

On a plain abdominal film the characteristic Rigler’s triad is seen in only a third of the patients\(^4\). It includes pneumobilia, intestinal obstruction and ectopic gallstone. CT may demonstrate Rigler’s triad and is useful in identifying the site of the gallstone impaction\(^5\).
Teaching points

Colonoscopic stricture dilatation and stone removal is the treatment of choice[3]. If this fails, laparotomy and colotomy, and rarely resection is required[5]. The cholecystocholic fistula is usually symptomless and therefore no treatment is required[3].

References