A 56-year-old male was admitted to our department with a 2-month history of recurrent lower abdominal pain accompanied periodically by fever. He had lost 7 kg in weight and had no history of melena or change in bowel habits or stool caliber. Plain abdominal radiography and computed tomography (CT) scans were normal. Colonoscopy revealed a wooden toothpick of 7 cm in length that had impacted with both ends embedded in the sigmoid wall at the rectosigmoid junction. Mucosal edema and erythema were also apparent (Fig. 1).

The procedure was difficult due to the position of the toothpick and very active peristalsis. The postprocedure abdominal radiography was negative for pneumoperitoneum. Intravenous treatment with broad-spectrum antibiotics was started and continued for 7 days; the patient made a full recovery.

Retrospective anamnesis revealed that the patient had eaten meat rolls and a large volume of alcoholic drinks during a party about 5 weeks before.

Most ingested foreign bodies pass through the gastrointestinal tract spontaneously without any adverse effects. However, 10–20% require endoscopic removal and about 1% require early surgery [1]. Complications after foreign body ingestion occur at sites of angulation or physiologic narrowing of the gastrointestinal tract, such as the pylorus, the ligament of Treitz, the ileocecal valve, or the rectosigmoid junction [2]. Accidental ingestion of long, narrow, or pointed foreign bodies, such as a toothpick, is associated with a higher risk of impaction and perforation of the gastrointestinal wall, with surgical intervention being required in 15–35% of cases [2,3]. Sensitivity of endoscopy in detecting gastrointestinal foreign bodies is estimated to be about 70% compared with 9%, 15%, and 29% for radiography, CT scan, and ultrasonography, respectively [4]. When impaction of such foreign bodies is diagnosed in time, successful endoscopic management is possible.

Competing interests: None

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R. Grabysa1, R. Łowczak1, M. Kubiak1, M. Kowalczyk2, P. Zaborowski1
1 Department of Internal Diseases, Gastroenterology and Hepatology, University Hospital, Warmia and Mazury University, Olsztyn, Poland
2 Department of General and Minimally Invasive Surgery, University Hospital, Warmia and Mazury University, Olsztyn, Poland

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Corresponding author
R. Grabysa, MD, PhD
Department of Internal Diseases, Gastroenterology and Hepatology University Hospital Warmia and Mazury University Warszawska 30 10082 Olsztyn Poland
Fax: +48-89-5413093
rgraby@wp.pl