

Endoscopic removal of gallstone impacted in the rectum



Fig. 1 Endoscopic image of the peach pit-like foreign body impacted in the rectum.



Fig. 2 The gallstone which was extracted from the rectum.

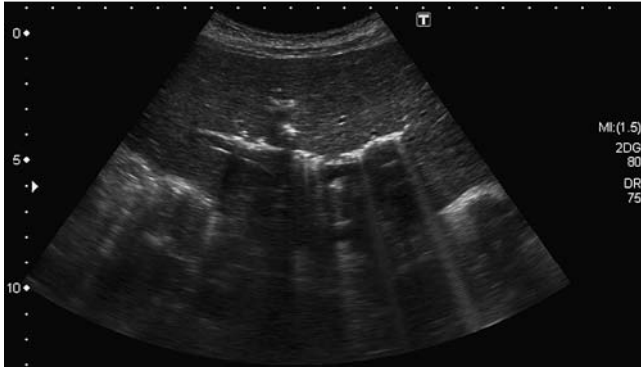


Fig. 3 Ultrasound image showing pneumobilia.



Fig. 4 Fistulous orifice at the hepatic flexure of the colon. No bile drainage was noted from the fistulous orifice.

A 65-year-old woman was admitted to hospital complaining of rectal discomfort that had begun 2 months earlier. Sigmoidoscopy revealed a round object about the size of a peach pit, which was covered by nonbloody semisolid stools (▶ **Fig. 1**). With the woman under mild anesthesia, the object was extracted by polypectomy snare and identified as a large gallstone of 6 × 4 cm (▶ **Fig. 2**). An abdominal ultrasound showed pneumobilia (▶ **Fig. 3**). A biliary-enteric fistula was suspected, although the patient was totally asymptomatic; in particular, the patient had never complained of symptoms suggestive of acute cholecystitis. After the gallstone had been extracted from the rectum, the woman underwent gastroscopy (negative) and colonoscopy, which showed a fistulous orifice near the hepatic flexure, with no bile discharge (▶ **Fig. 4**). A one-stage procedure involving cholecystectomy and fistula resection was performed, resulting in an excellent postoperative clinical course.

Cholecystoenteric fistulas (CEFs) are rare entities characterized by the formation of an abnormal communication between the gallbladder and the bowel wall, often resulting in the passage of a gallstone [1]. Previous episodes of acute cholecystitis are often reported. Two main types of CEF have been described: the cholecystoduodenal fistula and the cholecystocolonic fistula. Most CEFs have an indolent course, although chronic bile acid-induced diarrhea with malabsorption and weight loss has been reported. In one-fifth of patients, CEFs are complicated by gallstone ileus [2]. Impaction of a gallstone in the rectum is exceptional; until 2000, only three cases had been reported, all associated with cholecystocolonic fistulas [3–5].

Extraction of impacted stones is difficult. In our case, the gallstone was removed through the anus by means of a polypectomy snare. The Dormia basket was not used, to avoid any potential device impaction. When endoscopic procedures fail, laparotomy becomes necessary.

After gallstone removal, CEFs can be repaired in a one-stage surgical procedure along with cholecystectomy. However, in elderly patients at high surgical risk, CEFs may be treated conservatively even if the risk of recurrent biliary ileus remains elevated.

Endoscopy_UCTN_Code_TTT_1AQ_2AH

Competing interests: None

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Bibliography

DOI 10.1055/s-0030-1256949
Endoscopy 2011; 43: E408–E409
© Georg Thieme Verlag KG Stuttgart · New York ·
ISSN 0013-726X

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