Gallstone ileus

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Gallstone ileus is an infrequent complication (0.4%) of cholelithiasis, occurring as a result of impaction of one or more gallstones within the gastrointestinal tract. It is seen more Leon Bouveret , 1850–1929, physician, Lyon, France. a These three constitute Rigler’s triad. Leo George Rigler , 1896–1979, Professor of Radiology , University of California, Los Angeles, CA, USA. of acute cholecystitis leads to erosion of inflamed tissues, resulting in a cholecystointestinal fistula. A majority of small gallstones pass through the intes - tines spontaneously . However, g allstones of size 2–5 /uni00A0 cm get impacted, usually in the terminal ileum or at the ileocecal valve owing to the relatively narrow lumen and less active peristal - sis here. Less common locations include the stomach and the duoden um (Bouveret’s syndrome). Impacted stones may lead to necrosis and perforation followed by peritonitis. Clinical manifestations include acute, intermittent or chronic episodes of partial or complete gastrointestinal obstruction. Physical examination may be non-specific or may show signs of obstruction: dehydra tion, abdominal distension and tenderness, with high-pitched bowel sounds, and obstruc - tive jaundice. A plain abdominal radiograph shows: a /uni25CF partial or complete intestinal obstruction; a /uni25CF pneumobilia or contrast material in the biliary tree; a /uni25CF an aberrant rim-calcified or total-calcified gallstone; - /uni25CF a change in the position of such a gallstone on serial films (‘tumbling sign’). - CT is considered superior to plain radiographs or USG, with a sensitivity of up to 93%. It additionally shows an abnor - mal gallbladder with air, an air–fluid level or fluid accumula - tion with an ir regular wall. In addition to the management of intestinal obstruction, enterolithotomy has been the most common surgical procedure performed. A longitudinal incision is made on the antimesen - teric bor der proximal to the site of gallstone impaction, and the gallstone is brought proximally to a non-oedematous segment of the bowel by gentle manipulation and extracted. A chole - cystoenteric fistula should not be resected unless the patient is stable and there ar e residual gallstones that may cause infection or recurrent ileus (see Chapter 78).

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