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Accepted Article

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Title

Gallstone ileus in an elderly orthopaedic patient managed with enterolithotomy: A video vignette

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Conflicts of interest

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Accepted Article

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To whom it may concern,

Gallstone ileus accounts for up to 25% of mechanical small bowel obstruction in patients >65. Surgery in this age group can be associated with increased complications due to advancing age and co-morbidities. The attached video (Video S1) describes a case of gallstone ileus in a 78 year-old woman managed with minimally invasive enterolithotomy.

The on-call general surgical service were asked to see a 78 year-old woman with obstructive symptoms who was an inpatient under the orthopaedic team. A computed tomography scan had revealed small bowel dilatation with a 2cm calcified object within a small bowel loop. The patient was transferred to theatre for a diagnostic laparoscopy for suspected gallstone ileus.

A 10mm supra-umbilical incision was made with Hasson pneumoperitoneum. Small bowel dilatation was noted up to the level of a gallstone in the mid-small bowel with collapsed bowel distal to it. The small bowel proximal to this area was inflamed. The supra-pubic port was extended through the umbilicus and the small bowel was delivered and fully inspected. A 4cm longitudinal enterotomy was created proximal to the gallstone, through which it was removed. The enterotomy was then closed transversely with 3-0 vicryl in two layers and a subsequent leak test was negative. The patient recovered well, her nasogastric tube was removed, and oral intake was restarted over the next few days. This elderly patient was successfully managed with enterolithotomy alone. It is likely that a concomitant cholecystectomy would have led to additional, unnecessary postoperative morbidity.

Gallstone ileus narrative script

Preoperative

- A 78 year-old woman was admitted under the Orthopaedic team with a right-sided neck of femur fracture and underwent a hemiarthroplasty
- Her medications included clopidogrel and rivaroxaban
- Two weeks postoperatively she developed abdominal pain and vomiting
- The on call general surgical service were consulted
- A CT scan revealed a 2 x 2 cm calcified density in a small bowel loop within the mid abdomen with proximal bowel dilatation and a suggestion of a cholecystoduodenal fistula. Consistent with a gallstone ileus

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- The patient was given platelets and prothrombin complex concentrate and transferred to theatre for a diagnostic laparoscopy

Intraoperative

- After pneumoperitoneum was established, the small bowel was fully walked
- An inflamed loop of small bowel was noted. This was inspected and determined to be viable
- A hard object was noted within the lumen just distal to this area and a grasper was placed adjacent to it
- The umbilical port was extended, and a wound retractor was inserted
- The abnormal loop of small bowel was delivered through the wound using the laparoscopic grasper and a babcock
- Again, the luminal gallstone was easily identified distal to the area of inflammation
- A 4cm longitudinal enterotomy was created proximal to the gallstone
- Which was then removed
- The enterotomy was then closed transversely in two layers with a 3-0 vicryl suture
- After insertion of two stay sutures, the midpoint of the enterotomy was closed
- With each suture, care was taken to bury the edges of the enterotomy
- After the first layer was completed, the corners were buried
- This was followed by completion of the second layer
- Here, the enterotomy has been fully closed
- A leak test was negative, and the bowel was reduced back into the abdomen
- The fascia at the umbilical port was closed with 1 PDS and the skin was closed with 4/0 monocryl after pulse lavage

Postoperative

- The patient had an uneventful postoperative recovery
- The nasogastric tube was removed, and oral intake was re-established over the next few days

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