

Clinical Image

Phytobezoar; A C.T Diagnosis

Sandeep Nijhawan*, Amritesh Kumar, Bir Singh and Gaurav Gupta

Department of Gastroenterology, SMS Medical College, India

*Corresponding author: Sandeep Nijhawan, Department of Gastroenterology, SMS Medical College, Jaipur, India, Tel: 9829272233; Email: dr_nijhawan@yahoo.com

Received: April 21, 2015; Accepted: April 23, 2015;

Published: April 27, 2015

Clinical Image

A 38 years female was admitted with complaints of recurrent colicky pain abdomen for 6months, abdominal distension, and obstipation for 3days. Patient had past history of pulmonary tuberculosis 1 year back for which she took antitubercular drugs for 6 months. She also had B12 deficiency anemia for 3month for which she was receiving parenteral injection of B 12. On physical examination patient had pallor and abdominal distension. X ray abdomen showed multiple air fluid levels. Routine hematological investigations were normal. Ultrasound abdomen showed dilated bowel loops.

Patient was kept nil by mouth, continuous rules tube drainage and intravenous fluids. After 72 hours of conservative management patient failed to pass stool and flatus and there was no decrease in abdominal girth. Patient underwent contrast enhanced computed tomography(C.E.C.T) abdomen which revealed a focal ovoid round intraluminal mass located in the distal ileum region with regular



Figure 1: Axial Image showing dilated proximal illeal loops with intraluminal Phytobezoar (↓) in distal illeum.



Figure 2: Coronal image showing phytobezoar (↓) with dilated bowel loops.

margins and a heterogeneous internal structure with mottled gas pattern (figure-1) suggestive of phytobezoar. In addition, the small intestine proximal to the mass was dilated; the distal illeal loops had a normal diameter suggesting intestinal obstruction (Figures 1 & 2).

Patient underwent surgery where phytobezoar was found in distal ileum proximal to illeal stricture. Resection of stricture with end to end anastomosis and removal of phytobezoar was performed. Postoperative course was uneventful.

Bezoar is a mass of swallowed foreign indigestible material found within the gastrointestinal tract. Despite the fact that bezoars are a rare cause of intestinal obstruction, this emergency pathology is a frequently encountered problem worldwide [1]. Predisposing factors in bezoar formation include systemic diseases that reduce gastrointestinal motility and previous peptic ulcer surgery [2]. CECT abdomen is superior to other radiologic tools for diagnosis of bezoar. In our case, patient had history of pulmonary tuberculosis, the illeal stricture was part of systemic tuberculosis involving ileum, and treatment must have led to fibrotic stricture. The obstruction and stasis proximal to the stricture must have led to formation of phytobezoar.

References

1. Menzies D, Ellis H. Intestinal obstruction from adhesions--how big is the problem? *Ann R Coll Surg Engl.* 1990; 72: 60-63.
2. Escamilla C, Robles-Campos R, Parrilla-Paricio P, Lujan-Mompean J, Liron-Ruiz R, Torralba-Martinez JA. Intestinal obstruction and bezoars. *J Am Coll Surg.* 1994; 179: 285-288.