Key words: Cholecysto-enteric fistula, gallstone ileus

Bouveret's syndrome (BS) is a rare complication of gallstones, characterized by gastric outlet obstruction due to a large stone impacted in the proximal duodenum consequent to a cholecysto-duodenal fistula.\(^1\)\(^2\)

A 47-year-old man presented with epigastric pain, recurrent vomiting and low-grade fever since three days. He was diagnosed to have cholelithiasis on ultrasonography performed six months earlier for dyspeptic symptoms. Examination revealed mild dehydration. Vital signs were within normal limits. There was minimal tenderness in the epigastrium and right upper quadrant. Hematological and biochemical investigations including liver function tests were normal. Esophagogastroduodenoscopy revealed an extrinsic bulge in the antro-pyloric region. Further manoeuvring of the endoscope showed a large yellow-brown, oval stone impacted in the duodenal bulb and causing obstruction (Fig. 1a). An attempt to disimpact the stone with foreign body forceps failed. Dormia basket retrieval too failed since it could not be passed beyond the impacted stone. The patient was managed conservatively with naso-gastric aspiration, intravenous fluids, and broad-spectrum antibiotics.

Repeat endoscopy the day after showed pus in the duodenal bulb. There was, however, no evidence of the stone (Fig 1b). The duodenal mucosa was inflamed. The endoscope could be easily negotiated into the second and third parts of the duodenum. Ultrasonography revealed a thick-walled gall bladder with minimal pericholecystic fluid collection but no stone in the gall bladder. Plain X-ray of the abdomen did not reveal any ectopic radio-opaque gallstone. The symptoms resolved dramatically. He continues to be symptom-free two years later with no further stones in the gall bladder.

In a majority of cases gallstones that enter the intestinal tract through a cholecysto-enteric fistula are passed spontaneously; 6% develop clinical obstruction. The terminal ileum is the commonest site (60%), followed by the proximal ileum (24%) and jejunum (9%). In 1%-3% of cases the stone may obstruct the duodenum, usually in its distal portion. Impaction in the pyloric region and duodenal bulb causing gastric outlet obstruction (Bouveret's syndrome) is the least common.\(^1\)

The classical triad of distended stomach, pneumobilia and ectopic radio-opaque gallstone on plain X-ray of the abdomen is diagnostic of Bouveret's syndrome but is seen in only a third of cases.\(^3\) Pneumobilia may not always be detected and gallstones are radiolucent in the majority of cases.\(^1\) Contrast radiology, CT scanning or upper GI scopy are required to confirm the diagnosis.\(^2\)

Endoscopy is rarely therapeutic, because it is difficult to dislodge and retrieve the large impacted stone. Recently successful treatment using laser lithotripsy\(^4\) has been reported. Surgical removal of the offending stone is the most accepted treatment.\(^1\)\(^2\) Cholecystectomy and repair of fistula in addition to enterolithotomy is recommended. This is debatable as the morbidity related to the bilo-enteric fistula is usually low.\(^2\) The present case was unique in that the patient had a fortuitous and uneventful passage of the impacted stone, which to our knowledge is the first report in literature of spontaneous resolution of Bouveret's syndrome.

References

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Perforation of jejunal non Hodgkin’s lymphoma

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Primary gastrointestinal lymphomas are rare. Jejunal non Hodgkin’s lymphoma presenting as perforative...
peritonitis is extremely rare. We report a 51-year-old man who presented with perforative peritonitis and was detected to have jejunal non Hodgkin's lymphoma. He was treated with resection of the affected segment with its mesentery and postoperative chemotherapy, and was asymptomatic 5 months later. [Indian J Gastroenterol 2004;23:110-111]

**Key words:** Small intestine tumor

Tumors of the small intestine are remarkably rare; only 3% to 6% of gastrointestinal tumors and 1% of gastrointestinal malignancies arise from the small bowel.1 Primary lymphomas account for <2% of all gastrointestinal malignancies and 10%-20% of small bowel malignancies.2 They are more common in the ileum, consistent with the higher number of lymphocytes there.3 Perforation of intestinal lymphomas is extremely rare.

A 51-year-old man presented with sudden onset pain in the periumbilical region since 3 days, increasing in severity since one day, with associated distention of abdomen. There was no history of vomiting or constipation, or ingestion of NSAIDs. On examination he was pale; there was no generalised lymphadenopathy. He had generalized distention of abdomen with tenderness, guarding and rigidity all over the abdomen. On auscultation there were no bowel sounds.

**Investigations:** Hemoglobin 9.2 g/dL, WBC 8,000/mm³. X-ray chest showed gas under both domes of diaphragm.

Emergency laparotomy revealed a perforated tumor mass, approximately 5 cm x 5 cm in size, in the jejunum about 16 cm to 18 cm from the duodeno-jejunal flexure, and another 3 cm x 2 cm lesion about 5 cm distal to the tumor mass with circumferentially thickened bowel. There were multiple hard lymph nodes in the adjacent mesentery. The liver, rest of the small intestine, stomach and large intestine were normal. There was around 800 mL of small bowel contents in the peritoneal cavity. The affected segment of jejunum was resected with a margin of 8 cm, along with adjacent mesentery and lymph nodes. Primary end-to-end anastomosis of the bowel was done after peritoneal lavage. Postoperative recovery was uneventful.

Histology of the resected segment revealed high-grade non Hodgkin's lymphoma of anaplastic large cell type. The patient was treated with combination of cyclophosphamide, vincristine and prednisolone. He followed up regularly for 5 months and was asymptomatic till then.

Perforation of a tumor can occur with surrounding desmoplastic resection and, therefore, primary closure is not advisable. Resection of the affected segment with its mesentery is the only acceptable procedure.1 Our patient had a perforated jejunal tumor mass, which was diagnosed as a primary GI lymphoma.3

In the treatment of a high-grade primary intestinal non Hodgkin's lymphoma of anaplastic large cell type, a multimodality approach is superior to surgery or chemotherapy alone.4 Prognostic factors include the stage at presentation, the presence of perforation, tumor resectability, histologic subtype, and the use of multimodality therapy. Perforated lymphomas usually have higher stage and bad prognosis.4

**References**


**Spontaneous perforation - a rare complication of choledochal cyst**

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We report a 2-year-old girl with spontaneous perforation of choledochal cyst. Preoperative diagnosis was possible by hepatobiliary scintigraphy. In view of emergency presentation and bile peritonitis, management was a staged procedure with peritoneal lavage and T-tube drainage of the biliary system, followed by exclusion of the cyst and Roux-en-Y hepatico-jejunostomy 3 months later. [Indian J Gastroenterol 2004;23:111-112]

**Key words:** Bile duct cyst, nuclear scan, rupture

Spontaneous perforation is a rare and ill understood complication of choledochal cyst (CDC). A 2-year-old girl presented with sudden onset severe pain in the abdomen followed by progressive abdominal distention and jaundice, of two weeks' duration. There was history of refusal to accept feeds, vomiting and constipation for two days. Examination revealed moderate dehydration and tachycardia. The child was mildly febrile, with obvious icterus. There was significant abdominal distention with diffuse abdominal tenderness. Bowel sounds were absent.

**Investigations:** TLC 12,500/mm³, serum bilirubin 4.2 mg/