

Swallowed Fish Bone Expelled Spontaneously after Perforating the Small Bowel

Dear Editor,

We report an unusual case of an elderly gentleman with small bowel perforation secondary to a swallowed fish bone, who spontaneously expelled the foreign body (FB) on the day before his planned surgery, almost 2 months after the ingestion.

The patient is an 81-year-old Chinese gentleman, with a history of anterior resection 4 years earlier for stage II rectal cancer and laparoscopic cholecystectomy 2 months earlier for symptomatic gallstones. He presented to the emergency department (ED) with acute onset of central colicky abdominal pain without fever or vomiting. Abdominal examination was unremarkable except for the expected scars from the previous surgeries. The symptoms resolved with conservative management.

Over the next 6 weeks, he re-presented to the ED twice with non-specific recurrent gastrointestinal (GI) symptoms and was referred to the surgical clinic. An outpatient computed tomography (CT) scan was performed.

The CT scan was done 7 weeks after his first visit to the ED. Sagittal reconstructed (Fig. 1A) and axial (Fig. 1B) images revealed a curvilinear 4.5 cm density in the lumen of small bowel, extending extraluminally anteriorly. There were also gas loculi around the sharp extraluminal

component. These gas loculi were surrounded by inflamed, stranded peritoneal fat, compatible with a sealed perforation. No intraperitoneal free gas was detected in the expected non-dependent portion of the peritoneal cavity.

Upon further questioning, the patient recalled eating a meal of fish shortly before his initial presentation and remembered swallowing something hard. Surgical removal of the foreign body was planned. However, a day before the surgery, the patient returned to the clinic with a 5 cm long blackened fish bone, which he claimed to have defecated earlier that day (Fig. 2). The morphology of the bone corresponded to the image seen on CT. He was asymptomatic and the surgery was cancelled. At interval follow-up 3 months later, he remained asymptomatic.

Dietary FB perforation of the GI tract is uncommon and is extremely difficult to diagnose due to its wide spectrum of non-specific clinical presentation.¹ In this particular patient who has had 2 previous abdominal surgeries, it is not surprising that the diagnosis of the more common adhesion colic was more in favour than the remote FB perforation of the GI tract. Further, despite the GI perforation, there was no evidence of sepsis and during each episode, his symptoms were well-controlled conservatively.

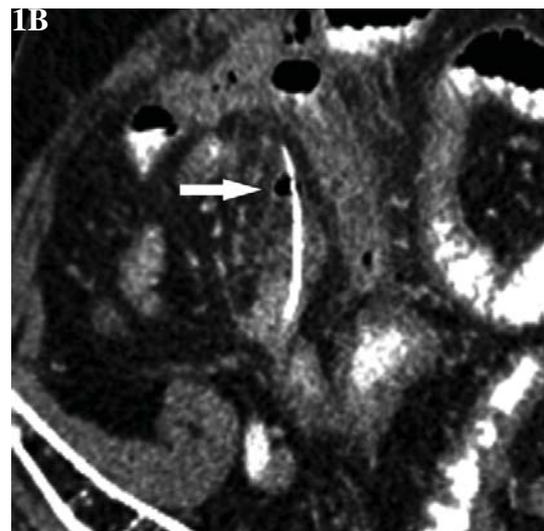
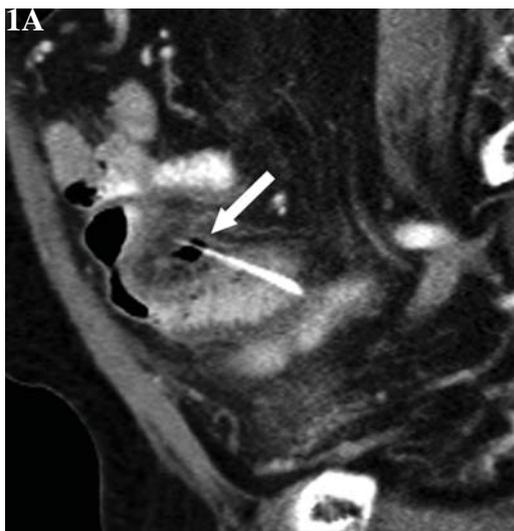


Fig. 1A (left) and Fig. 1B (right). Sagittal reconstructed and axial slices respectively of the CT abdomen and pelvis revealing a 4.5 cm curvilinear FB protruding out of the distal small bowel lumen anteriorly. The extraluminal component is surrounded by fat stranding and gas loculi (arrows), in keeping with a sealed perforation.

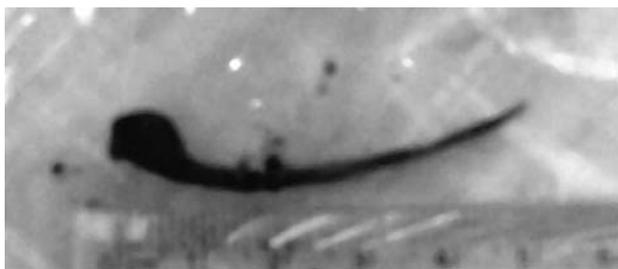


Fig. 2. The 4.5 cm fish bone that was passed out spontaneously by the patient on the day prior to his planned surgery, almost 2 months after the initial onset of symptoms.

Due to their sharp ends and elongated shape, accidentally ingested fish bones are the most common FB to cause GI tract perforations.^{1,2} FB perforation of the GI tract is caused by impaction and progressive erosion of the FB through the bowel wall, with the site of perforation sealed by fibrin, omentum or adjacent bowel loops,³ corresponding to the CT scan findings. The thicker part of the FB was still intraluminal; this may explain why it could still be dislodged and passed out naturally.

REFERENCES

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