GALLSTONE ILEUS: AN UNUSUAL CAUSE OF SMALL BOWEL OBSTRUCTION AFTER LIVER TRANSPLANTATION

Ahmed Elkafrawy[1], MD; Mohamed Ahmed [2], MD; Antonio Sanchez, MD[1]

1. University of Iowa Hospitals and Clinics
2. University of Missouri Kansas City

Background

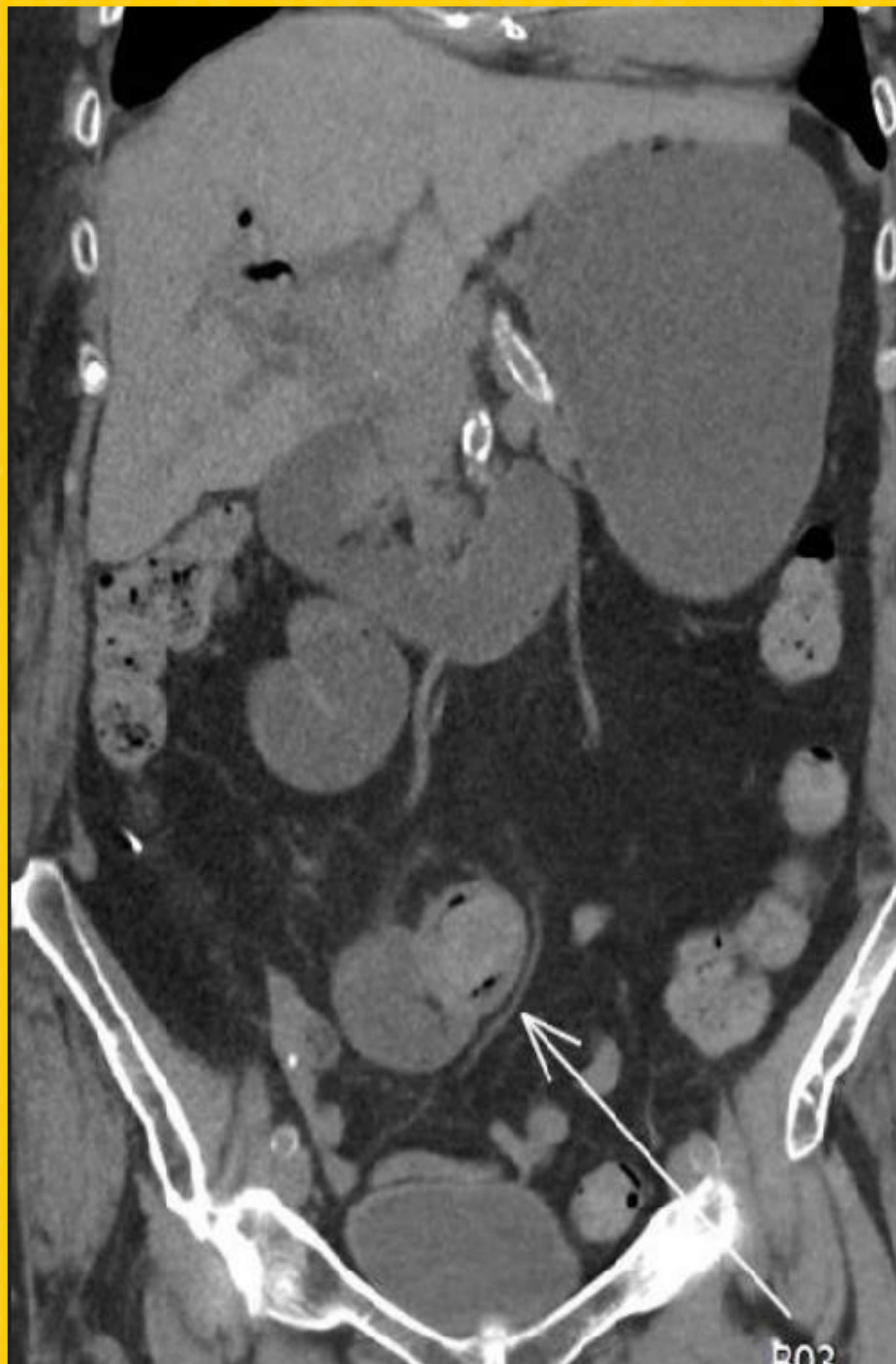
- Liver transplantation is the only curative treatment for patients with decompensated liver disease
- The prevalence of biliary complications after a DCD liver transplant is estimated between 10 to 15%. Biliary leaks and strictures are the most common biliary complications
- We are presenting a rare case of gallstone ileus at the afferent limb in a patient with a complicated post-liver transplant course

Case Description

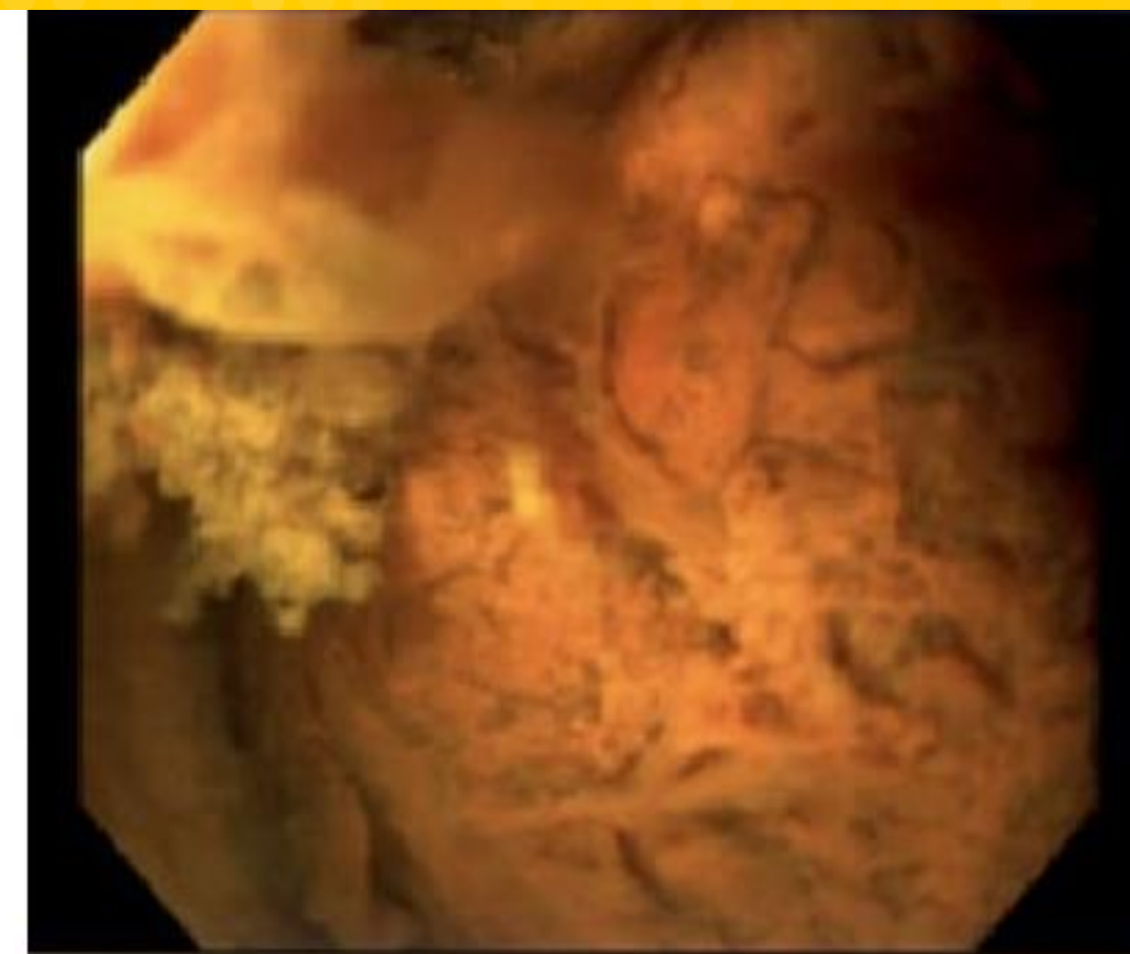
- A 78-year-old female with a history of NASH cirrhosis for which she underwent a DCD liver transplant ten years before presentation
- Post-transplant course was complicated by anastomotic biliary strictures, recurrent choledocholithiasis, and recurrent cholangitis requiring multiple ERCPs with placement of multiple biliary stents

Discussion

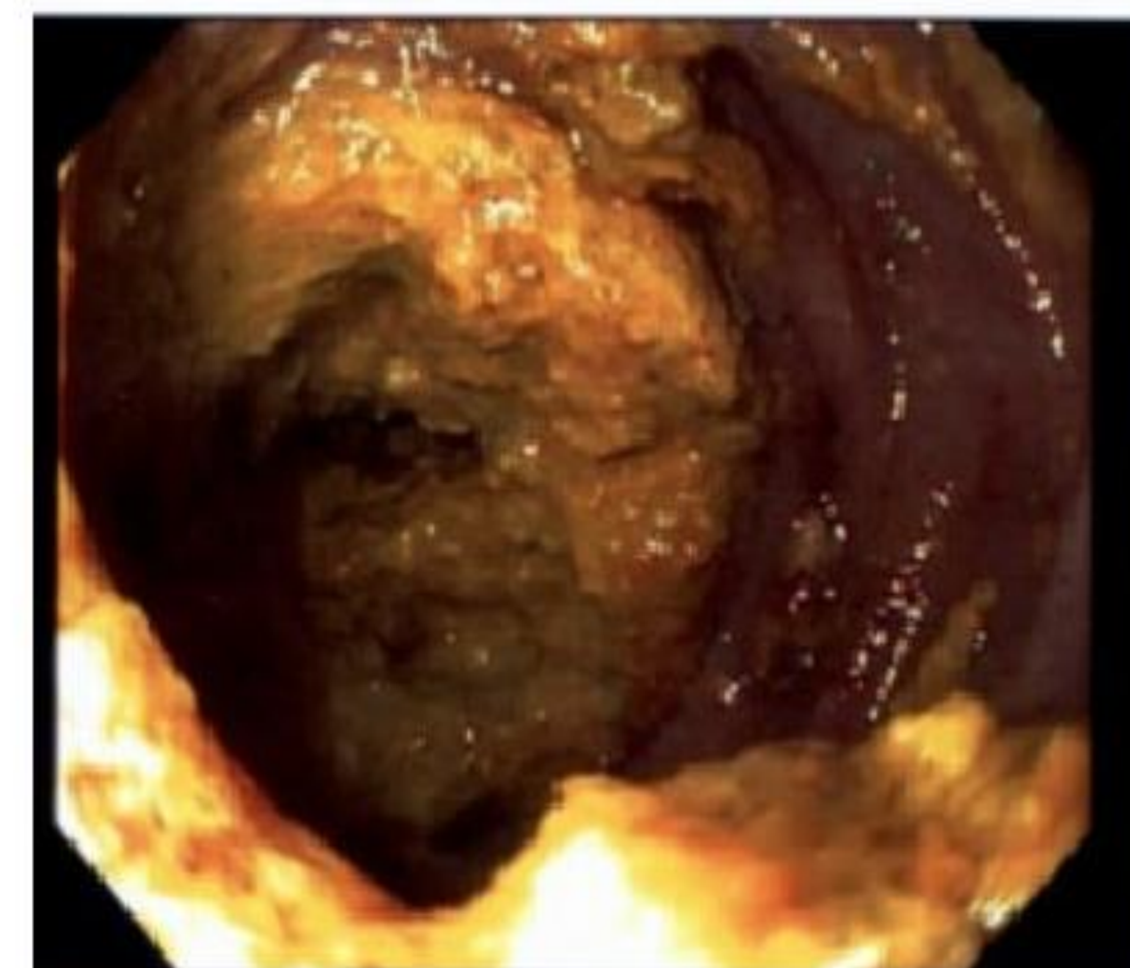
- Biliary leaks and strictures are the most common biliary complications following liver transplant
- Gallstone ileus should be considered in liver transplant patients presenting with small bowel obstruction, especially if they have a history of recurrent biliary complications
- Prompt recognition of this complication is key, endoscopic lithotripsy should be attempted first in these patients as they are usually high risk surgical candidates



Panel A



Panel B



Panel C

Panel A: CT abdomen and pelvis showing dense luminal material at the transition point.Panel B: Endoscopicimage of the cholesterol stone occluding the lumen before lithotripsy.Panel C: Endoscopic image of the cholesterol stone after the lithotripsy

UNIVERSITY OF IOWA HEALTH CARE

Sponsored by the Bruce L. Miller & M. Joyce Miller Memorial & Visiting Professorship

Case Description

- She underwent Roux-en-Y hepaticojejunostomy three years before presentation with marked improvement in the number of cholangitis episodes
- She presented with intractable nausea and vomiting. Physical exam showed abdominal distention and periumbilical tenderness
- Labs were significant for a mild rise in serum creatinine but no leukocytosis and liver chemistries were normal
- CT abdomen revealed small bowel obstruction with a transition point at the right lower quadrant anastomosis suspecting phytobezoar at the jejuno-jejunal anastomosis
- The patient underwent push enteroscopy to decompress the obstructed limb and remove the suspected food material

- The scope was advanced to the jejuno-jejunal anastomosis. About 15 cm beyond the afferent limb, the lumen was entirely occluded by a giant stone measuring (3.5 cm x 2.5 cm)
- The stone had sequential rings and appeared as a cholesterol stone
- The stone was fragmented using grasping forceps, snares, and dilating balloons into 15-20 smaller stones over three hours duration
- The scope was advanced beyond the fragmented stones. A nasogastric tube was inserted for decompression
- Patient symptoms resolved following the procedure, and she was discharged home with no recurrence