Gallstone ileus in an ‘asymptomatic’ parastomal hernia

H Jayamanne, J Brown, BM Stephenson

Aneurin Bevan University Health Board, UK

ABSTRACT

Parastomal hernias are common and often asymptomatic. We report the first known case in which later, acute symptoms developed owing to gallstone ileus in a sac containing both omentum and small bowel. Urgent computed tomography established the diagnosis.

KEYWORDS

Gallstone ileus – Parastomal hernia

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CORRESPONDENCE TO

Brian Stephenson, E: brian.stephenson@wales.nhs.uk

Parastomal hernias, whether following the formation of an ileostomy or colostomy (loop or end), may be managed conservatively akin to a policy of ‘watchful waiting’. Such a decision is clearly dependent on many factors including the patient’s symptoms, age and co-morbidities.

Case history

A 71-year-old obese woman underwent preoperative long course chemoradiotherapy for anorectal cancer with a threatening circumferential resection margin. Ten weeks later, she underwent an uneventful laparoscopic abdominoperineal resection. The stoma site was not augmented with prophylactic mesh. The final histology indicated yT2 yN0 (Dukes’ A) cancer. She underwent regular computed tomography (CT) and endoscopic surveillance for four years, and was then discharged. Her last CT showed a small asymptomatic parastomal hernia containing omentum but no other abnormality.

Three years later (now aged 78 years), the patient presented with recurrent episodes of vomiting, thought initially to be due to gastroenteritis. Although two episodes settled, she then presented acutely with a non-functioning stoma. CT confirmed small bowel obstruction and a large solitary gallstone (3cm) in incarcerated small bowel loops in the sac of the previously asymptomatic hernia (Fig 1). At laparotomy, the omentum was excised and the loops were reduced. The impacted non-faceted stone was milked proximally and removed with closure of the hernial defect. The patient was discharged seven days after surgery.

Discussion

An exhaustive search of the literature on PubMed has not identified a similar case. However, one report documents a

similar scenario in an elderly man with a longstanding end ileostomy for chronic ulcerative colitis fashioned four decades earlier.¹ There was no apparent parastomal hernia and this case of gallstone ileus followed recent endoscopic retrograde cholangiopancreatography for symptomatic septic choledocholithiasis and so was strictly of different aetiology.

Figure 1 Computed tomography showing a solitary large gallstone in a parastomal hernia

Although gallstone ileus is relatively uncommon, it has an attendant mortality, especially as patients are elderly and often have co-morbid conditions. Indeed, simple enterolithotomy of the small bowel is the preferred management as opposed to surgery for any underlying bilioenteric fistula.² This is the approach that we took on our patient's acute surgical admission.

Finally and irrespective of this patient's later unusual complication, should we repair all asymptomatic parastomal hernias? The answer is probably 'no' and undeniably, this approach appears safe in incisional hernias.⁵ This is particularly the case in patients with a high body mass index. In fact, of 500 patients reviewed at 3 years, only 11% developed symptomatic hernias after abdominoperineal excision regardless of the surgical technique employed.⁴ Nevertheless,

we await the results of ongoing attempts to lower the incidence of later stomal herniation.⁵

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