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Case Report

Unusual Presentation of Small Bowel Obstruction

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Abstract

A 43-year-old previously healthy retired soldier from Horowpothana in Sri Lanka presented initially with left loin-to-groin pain suggestive of left ureteric colic. He first sought traditional treatment from a local exorcist, after which his abdominal pain worsened, prompting admission to a local hospital where symptoms were temporarily relieved with medication. Laboratory investigations, including serum electrolytes and amylase, were normal. Plain abdominal X-ray showed dilated small bowel loops, and CECT abdomen demonstrated dilated small bowel loops with a transition point at the distal ileum, consistent with a diagnosis of mechanical small bowel obstruction.

This case highlights the importance of early medical evaluation in acute abdominal pain and the potential risks of delayed presentation due to initial reliance on traditional or non-medical interventions. A seemingly benign presentation such as ureteric colic may mask or evolve into a surgical abdominal emergency like small bowel obstruction. Careful clinical reassessment, early imaging (especially CECT), and timely referral are crucial to identify a transition point and prevent complications such as bowel ischemia or perforation.

Keywords: Small bowel obstruction, Enterotomy

Introduction

Small bowel obstruction is a common surgical emergency resulting from mechanical or functional disruption of intestinal transit. This condition is most frequently caused by post-operative adhesions, hernias, tumors and less likely to be caused by volvulus, gallstone ileus, foreign body, undigested food particles, worm infestation and endometriosis (1). Small bowel obstruction secondary to ingested food particle is an extremely rare occurrence especially in the middle age and less than 1% of cases necessitating surgical intervention (2). The pathophysiology includes bowel distension, impaired venous return, mucosal ischemia, bacterial translocation and in severe cases necrosis, perforation and peritonitis. Diagnosis involves clinical assessment and imaging with CT being the gold standard to identify the transient point, ischemia or perforation.

Initial management includes fluid resuscitation, electrolyte correction and NG decompression with surgery indicated for strangulation, ischemia, tumor or unresolved obstruction (3).

Case report

43-year-old otherwise healthy retired soldier patient from Northern Central Province (Horowpothana) of SriLanka.

He has presented with the history of Left/Loin to groin pain and history suggestive of Left/ureteric colic. He sought the traditional treatment from an Exorcist in his rural village. After the rural treatment abdominal pain has worsened and admitted to local hospital. Initially pain was settled with medication.

Then, he developed central abdominal pain, that is colicky in nature and associated with abdominal distention and one episode of vomiting. Vomitus mainly contained undigested food. His abdominal distention

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has settled with vomiting. He has continuously passed the flatus with the small amount of bowel opening.

Then, his symptoms have got worsened further without bowel motion with the uninterrupted passage of the flatus. Then, He was transferred to Teaching Hospital, Anuradhapura for further management.

During the Examination, he was in discomfort with some features of dehydration and all the vital parameters were stable. His abdomen was virgin and hernial orifices were normal. His abdomen was distended with the exaggerated bowel sounds.

He had some non-specific abdominal tenderness without the features of peritonitis. He had stool in the Digital Rectal Examination.

Blood Investigations including Serum Electrolytes and Serum Amylase were normal. Plain-Supine-X-Ray-Abdomen revealed dilated small bowel loops. Contrast Enhanced Computed Tomography (CECT) abdomen has indicated that dilated small bowel loops with a transient point at the distal ileum.

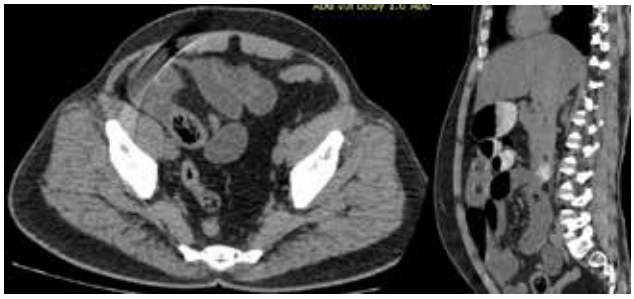

Figure: 1
CECT Abdomen – Axial view

Figure: 2
CECT Abdomen – Sagittal view

Diagnostic Laparoscopy has been planned with the preparation of Laparotomy. During the Diagnostic Laparoscopy, distended small bowel loops obscured the peritoneal cavity view.

Diagnostic laparoscopy was converted to an emergency exploratory laparotomy, which revealed distended but viable small bowel loops with a transition point in the distal ileum. A firm, hard, hemispherical intraluminal mass was identified in the distal ileum, close to the ileocecal valve, and was freely mobile proximally. The mass was milked proximally, followed by an enterotomy, through which a half-folded lime peel was retrieved. The enterotomy was closed with 3-0 polyglactin sutures. The patient had an uneventful postoperative recovery.

Figure: 3
Enterotomy with lime peel

Discussion

Small bowel obstruction is a common surgical emergency, contributing to 15% - 20% of hospital admissions for acute abdominal pain and accounting for approximately 80% of all bowel obstruction (4). The incidence of small bowel obstruction is closely associated with the prevalence of previous abdominal surgeries as post-operative adhesions are the leading cause, responsible for more than 75% of cases (5).

Even though, there were many commonly known causes for small bowel obstruction, rare cause also can give deleterious effect. Commonly intraluminal mases are obstructed at the ileum, ileo-cecal valve and recto-sigmoid. People who are living in Srilanka and other South Asia countries are still seeking exorcist treatment. In our patient also has sought the treatment for abdominal pain from a village exorcist and swallowed a half piece of lime without sipping in the mouth.

So, that undigested half folded lime peel has obstruct at

the distal ileum as unable to pass through the ileo-cecal valve as one of the known places for transient point in small bowel.

Conclusion

This case illustrates an unusual cause of small bowel obstruction resulting from the ingestion of a lime peel during traditional treatment. It highlights the need for awareness of cultural practices in clinical history taking and the importance of considering rare causes of obstruction, especially in regions where alternative therapies are commonly practiced. Prompt imaging and surgical management ensured a favorable outcome for this patient.

References

1. Intestinal obstruction: evaluation and management. Catena F, De Simone B, Coccolini F, et al. *Am Fam Physician*. 2018;98(6):362–367.
2. Small bowel obstruction secondary to phytobezoar. Erzurumlu K, Malazgirt Z, Bektas A, et al. *World J Gastroenterol*. 2005;11(12):1813–1817.
3. Bologna guidelines for diagnosis and management of adhesive small bowel obstruction (ASBO). Ten Broek RPG, Krielen P, Di Saverio S, et al. *World J Emerg Surg*. 2018;13:24.
4. Small bowel obstruction: a review of clinical presentation and management. Jackson PG, Raiji MT. *Curr Probl Surg*. 2011;48(11):681–735.
5. Small bowel obstruction: a review of clinical presentation and management. Jackson PG, Raiji MT. *Curr Probl Surg*. 2011;48(11):681–735