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Intestinal Obstruction Associated with Pharmacobezoar in a Patient with Crohn's disease

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Introduction: Crohn's disease (CD) is a chronic inflammatory bowel disease that affects any part of the gastrointestinal system, being more common between 15 and 40 years of age. Classic symptomatology includes diarrhea, vomiting, weight loss, abdominal pain, fever and malnutrition. Stenosis in CD varies from 12 to 54% frequency, it is more common in patients with already long term disease and the terminal ileum is the most commonly affected location.
The diagnosis is made through clinical data, radiological and histological findings, even without any characteristic that alone makes up the diagnosis of specific inflammatory bowel disease.

A bezoar is an accumulation of indigestible material that gets trapped in the gastrointestinal tract. These masses can be formed by different substances, which may be ingested either intentionally or accidentally. Some of the materials that can form bezoars include plant derivatives such as fibers, vegetable and fruit skins or seeds (known as phytobezoars), ingested hair (trichobezoars), and medications (pharmacobezoars).

A 30 years old, male patient, born in São Paulo, complaining of crampy abdominal pain for 3 months associated with weight loss, postprandial vomiting and some episodes of arthralgia. Denies diarrhea. He also reports having been submitted to drainage of a perianal abscess 2 years ago, and earlier on he had presented with hematochezia.

He was firstly evaluated at another service and submitted to computed tomography of the abdomen in which signs of ileitis and sub stenosis were identified. Despite the clinical signs, they hypothesized a diagnosis of celiac disease associated with nonspecific enteritis and introduced Mesalamine 2400 mg/day and suggested a gluten-free diet.

Two days after starting the medication, the patient had severe abdominal pain and fecal vomiting without improvement with symptomatic medication. He was in regular general condition, dehydrated, emaciated, afebrile, with a distended tense and painful on diffuse palpation abdomen, with a positive rebound tenderness test.

Complementary exams showed iron-deficiency anemia, leukocytosis and accentuated diffuse liquid distention in the ileal and jejunal loops, interspersed with segments of loops with parietal thickening/enhancement (Figure 1). Presence of hyperdense bodies (compressed?) inside the ileal loop on the left flank (figure 2). Therefore, the findings may correspond to active inflammatory bowel disease with associated intestinal subocclusion.

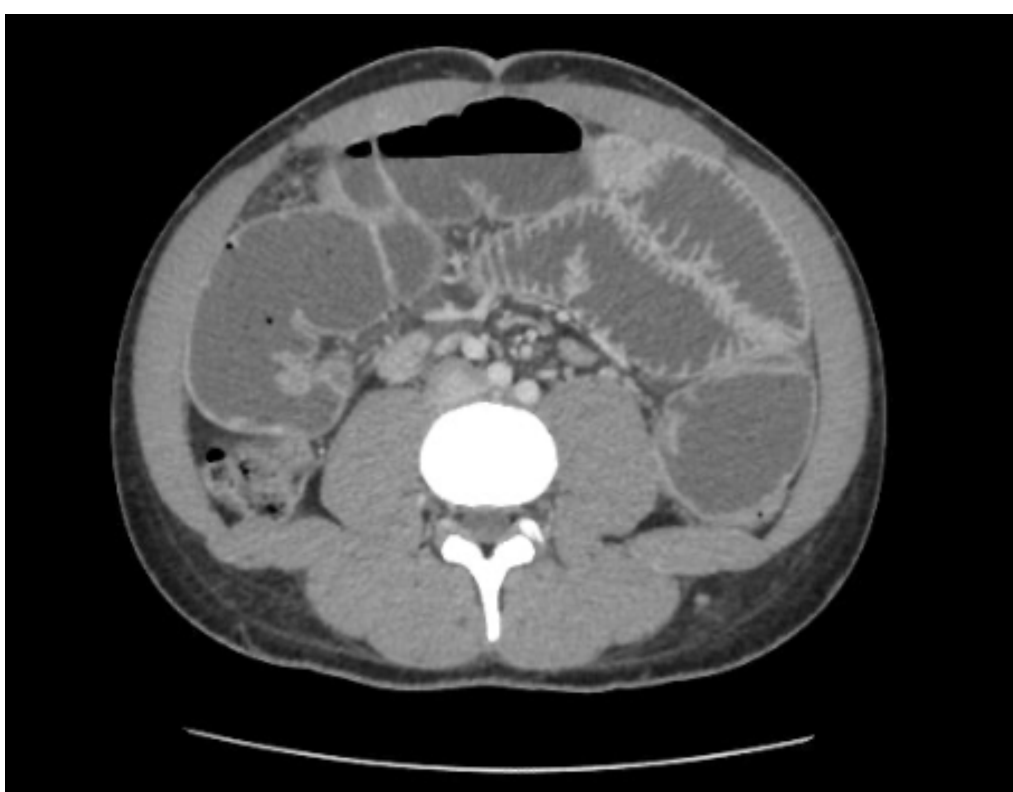

Figure 1: Tomography of the abdomen suggestive of involvement secondary to Crohn's disease

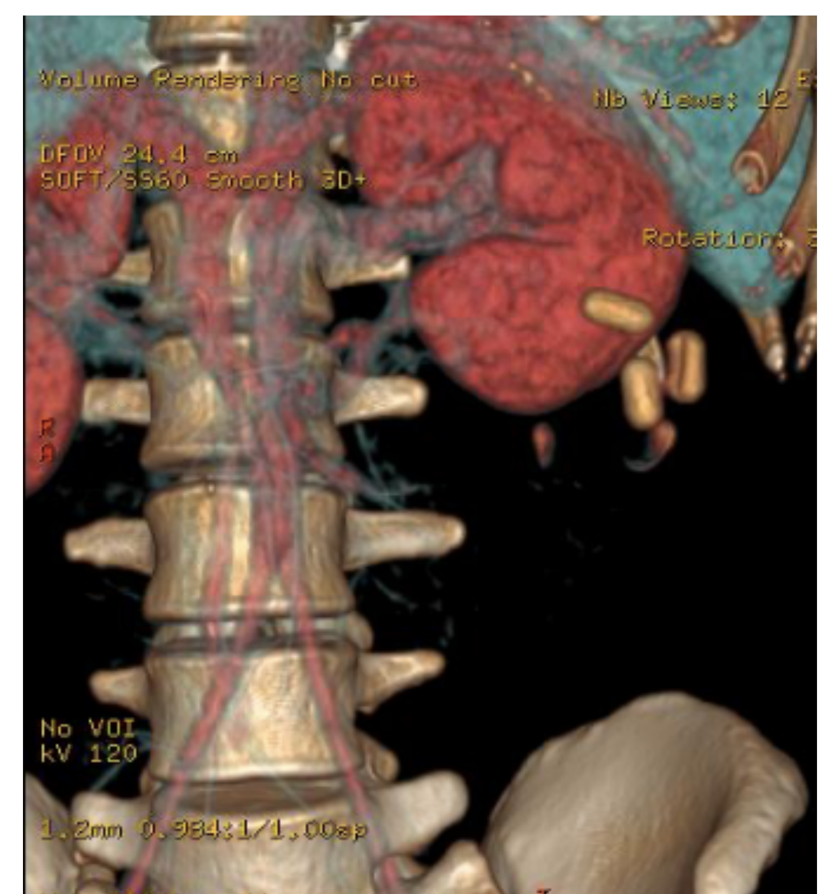

Figure 2: Tomography of the abdomen with 3D reconstruction demonstrating intact pills

In view of the findings, the patient was hospitalized urgently for corticosteroid therapy, parenteral nutrition, intravenous antibiotic therapy and insertion of a nasogastric tube.

He showed improvement of the subocclusive condition and new control image examination was performed which showed complete absorption of the pharmacobezoar. T

he patient was discharged after a week with a restricted diet, prophylaxis for Strongyloides and a negative tuberculin skin test for the initiation of immunobiologicals. At the moment, he is in outpatient follow-up, in clinical remission.

Conclusion: This report shows that there are still difficulties in identifying the disease, since CD isn't the most common diagnosis hypothesis and physicians end up researching infectious diseases and food intolerances first. The bezoar stood out as an incidental finding during the diagnostic investigation, however, to some degree, it may have contributed to the clinical picture presented by the patient. Both conditions were resolved with clinical treatment.

Thus, we reaffirm the individualized character of the clinic and therapeutic management in cases of pharmacobezoars, mainly in patients with inflammatory bowel disease.