

Unexpected outcome of a sigmoid lesion believed to be malignant

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Introduction

A 69-year-old male with a past medical history of an Olfactory nerve meningioma and left-sided Bell's palsy presented with 6 weeks of lower abdominal pain and weight loss of 4 kg in 6 months. His current medications included acetylsalicylic acid 80 mg once daily, Amlodipine 5 mg once daily and Allopurinol 300 mg once daily.

Physical examination was benign without signs of acute abdomen. The abdomen was nondistended and soft but tender to palpation over the left lower quadrant. Laboratory studies showed no acute outliers.

The patient was followed up by his pulmonologist because of thoracic lesions which required a PET-CT for further evaluation. This PET-CT revealed a focal zone of oedematous rectosigmoid colon with a strong suspicion of a semi-circular sigmoid neoplasia with continuation to the bladder (Figure 1a). A presumptive diagnosis of a primary colonic malignancy was made.

Colonoscopy was performed and visualised a foreign linear object lodged in both walls of the diverticular sigmoid with surrounding inflammation, but otherwise normal mucosa (Figure 1b). No arguments could be made endoscopically to support the diagnosis of an underlying primary colonic malignancy.

Question

What is your preferable technique to remove the foreign body?

Answer

We attempt a minimally invasive approach via colonoscopy. During the procedure, the linear object was grasped using a foreign body forceps and gently towed to the exit point one at a time with the bowel lumen maintained at the centre of the visual field to avoid mucosal injury. Once the object was removed, a second-look examination was performed to check for complications and no overt perforation was seen. The linear foreign body appeared to be a chicken bone (Figure 2).

The patient was discharged the same day of the procedure and he did not experience any discomfort, early complications or recurrence of symptoms. He was

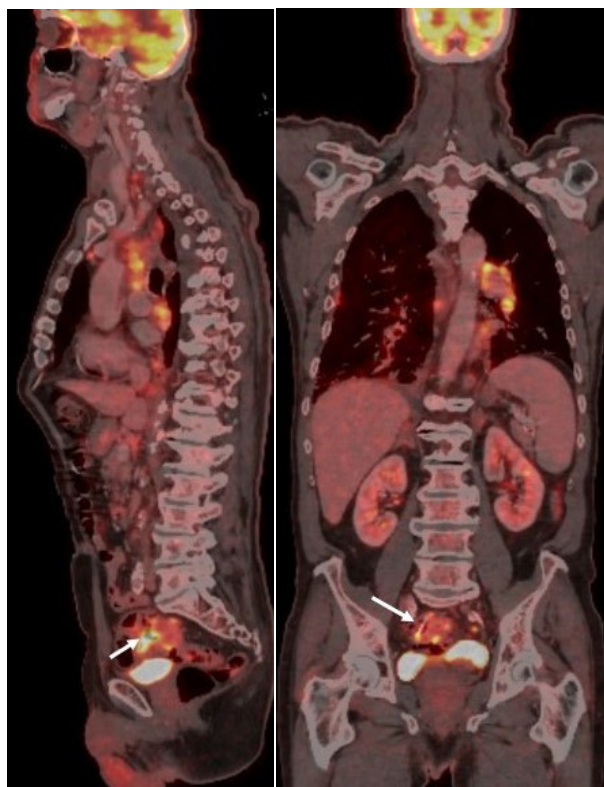


Figure 1a. — Coronal section of the Positron Emission Tomography showing a thickened rectosigmoid and an adjacent linear foreign body (arrow). Second image, transversal section of the Positron Emission Tomography showing the adjacent linear foreign body (arrow) and surrounding inflammation.

treated prophylactically with Amoxicillin-clavulanic acid for 5 days.

Our patient did accidentally ingest the chicken bone, probably while eating at the same time and did not recall the event. Most foreign bodies will pass through the gastrointestinal tract uneventfully, but long and pointy foreign bodies as presented in this case are more likely to require surgical or endoscopic removal (1,2). The

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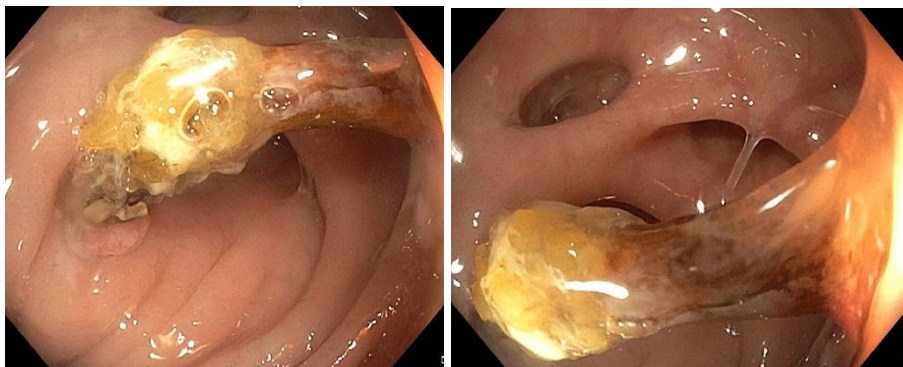


Figure 1b. — Endoscopic images showing one edge of the chicken bone lodged in the colonic wall of the diverticular sigmoid colon. Second image showing the other edge of the chicken bone in the colonic wall with surrounding reactive inflammation.



Figure 2. — Showing the removed chicken bone.

endoscopic bone removal prevented the development of complications requiring surgical treatment. This image highlights it is reasonable in stable patients

without peritoneal signs to attempt a minimally invasive approach via colonoscopy thereby reducing the need for surgery (3).

Keywords: Endoscopic removal, foreign body, diverticular sigmoid.

Conflict of interest

The authors have no potential conflict of interest relevant to this clinical image to be reported.

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