We report the case of an 87-year-old male patient with a history of arterial hypertension, dyslipemia, and early-stage Alzheimer’s disease. This patient came to the Emergency Department because of pain in his upper abdomen and right hypochondrium for 72 hours, together with low-volume vomiting (dark contents) and constipation for 4 days. Physical examination showed an acceptable general condition, no fever, normal BP, and normal cardiorespiratory status. The abdomen was soft, depressible, tender in the right hypochondrium on deep palpation, with metallic sounds, without lumps or organomegalies, and with no Murphy’s sign. There were no signs of deep venous thrombosis or edemas in the lower limbs.

At blood testing all parameters, including coagulation, general biochemistry with abdominal profile, and venous gasometry, were normal. When admitted the patient was submitted to abdominal X-rays while standing (Fig. 1), which showed a slight dilatation of the gastric cavity with a round image 2-3 cm in size with calcium-like density in the right hypochondrium.

The patient was admitted to the Digestive Department and submitted to intestinal fasting, analgesia, and a nasogastric tube connected to a nasogastric bag (with a brownish, fetid, liquid debit). After 24 hours the pain in the right hypochondrium had significantly diminished and there was a colicky pain in the periumbilical area with abdominal silence and inability to evacuate gas or feces. In the presence of a possible profile of intestinal obstruction, a second X-rays films of the abdomen in bipedestation (Fig. 2) revealed aerobilia, dilatation of the gastric cavity and almost the whole small bowel, and an image with calcium-like density of about 2.5 cm over the right lower quadrant.
In the presence of a profile of intestinal obstruction secondary to biliary ileus, the patient underwent surgery with enterotomy and extraction of a gallstone followed by enteroplasty. The outcome was satisfactory.

Biliary ileus is an infrequent cause of intestinal obstruction, only responsible for about 1 to 4% of cases (1,2). It is a true mechanical obstruction of the intestine produced by a gallstone of over 2 cm approximately or many stones blocking its lumen, most commonly located in the ileum (60%). Most typical is a cholecystoduodenal fistula through which the gallstone enters the intestine and sometimes, if the gallstone is small enough, goes through the ampulla of Vater. The diagnosis is mainly obtained by a clinical profile of intestinal obstruction confirmed by imaging techniques such as X-rays, CAT, etc. Surgery is the recommended therapy, as was with our patient (3).

REFERENCES