

# Ingested Fishbone Causing Pericolic Abscess

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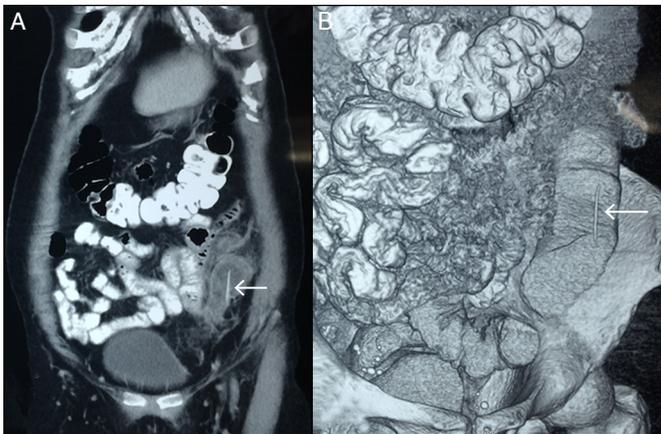
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## CASE REPORT

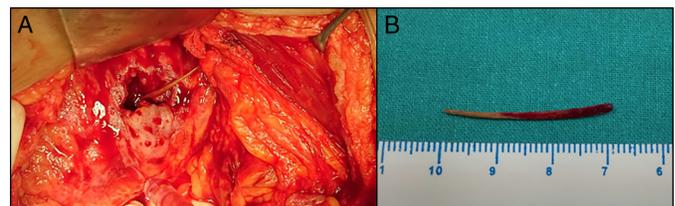
A 65-year-old diabetic woman presented to our clinic with a 10-day history of spasmodic lower abdominal pain, which eventually localized to the left iliac fossa. It was associated with low-grade fever for 3 days. Abdominal examination showed localized tenderness, guarding, and increased temperature. A tender, firm, non-mobile mass was palpated in the same region. Laboratory studies revealed leukocytosis with neutrophilia, and x-ray findings were inconclusive. Contrast-enhanced computed tomography (CECT) showed a loculated intraperitoneal hypodense fluid collection in left hemipelvis that displaced the bowel loops medially. The center of fluid collection had a thin, curved foreign body (Figure 1). A lower midline laparotomy was performed. An abscess cavity (8 x 6 cm) was drained, and the foreign body embedded in the cavity, later identified as a fish bone, was removed (Figure 2). No colonic perforation was evident. The abdomen was closed with a drain, and the patient had an uneventful recovery.

Accidental ingestion of fish bones is not uncommon, and related complications are well documented, especially in the Asian population.<sup>1</sup> It requires a high degree of suspicion as the patient is unable to provide an appropriate history. In a case report by Hakeem et al, there was a 10-month delay in diagnosis of a fish bone perforation of the small bowel with a localized fluid collection.<sup>1,2</sup> Only in 1% cases does the foreign body cause complications such as obstruction and perforation. Dangoisse and Laterre have reported a case of an impacted fish bone in the left lobe of the liver after it perforated the stomach.<sup>3</sup>

Fish bones are not easily diagnosed on plain radiographs because of the low bone density of some fish species.<sup>1</sup> Diagnosis on a CECT scan can also prove to be difficult as the calcification of a fish bone can be obscured by contrast.<sup>1</sup> An explorative laparotomy provides many advantages in the management of the given case scenario. The presence of the foreign body can be confirmed along with the exact location, and the pus from the cavity can be sent for culture and sensitivity. Cases with larger perforations and abscess cavities may require suturing, resection, and exteriorization in the form of colostomy. The other option of minimally invasive laparoscopy should also be considered in cases with no peritoneal contamination.<sup>1,4</sup> The decision for laparotomy versus laparoscopic surgery has to be made on a case-by-case basis.



**Figure 1.** (A) Sagittal CECT of the abdomen with (B) a 3-dimensional reconstruction showing a curvilinear foreign body embedded in an abscess cavity.



**Figure 2.** (A) Intraoperative image showing pericolic abscess and (B) a 3-cm fish bone.

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## DISCLOSURES

Author contributions: K. Gupta collected the data, reviewed the literature, wrote the manuscript, and is the article guarantor. SM Madhavan reviewed the literature and critically revised the manuscript. AJ Augustine critically revised the manuscript.

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