

Stone In Disguise: Enterolith Ileus Mimicking Gallstone Ileus - A Rare Clinical Imitator¹Dr Priyanka A., Junior Resident-2, Department of General Surgery, KVG Medical College, Sullia, Karnataka²Dr Gopinath Pai, Professor and HOD, Department of General Surgery, KVG Medical College, Sullia, Karnataka³Dr Ranjith K B, Professor, Department of General Surgery, KVG Medical College, Sullia, Karnataka**Corresponding Author:** Dr Priyanka A. Junior Resident-2, Department of General Surgery, KVG Medical College, Sullia, Karnataka.**How to citation this article:** Dr Priyanka A., Dr Gopinath Pai, Dr Ranjith K B, “Stone In Disguise: Enterolith Ileus Mimicking Gallstone Ileus - A Rare Clinical Imitator”, IJMACR – July – 2026, Volume – 9, Issue – 4, P. No. 15 – 17.**Open Access Article:** © 2026 Dr Priyanka A, et al. This is an open access journal and article distributed under the terms of the creative common’s attribution license (<http://creativecommons.org/licenses/by/4.0>). Which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.**Type of Publication:** Case Report**Conflicts of Interest:** Nil**Introduction**

- Enterolithiasis was first described by Chomelin after discovering a stone in a duodenal diverticulum during autopsy¹.
- Gallstone ileus is an uncommon but recognized cause of mechanical small bowel obstruction (SBO), typically arising from a cholecysto-enteric fistula.
- In contrast, enterolith ileus, especially secondary to tubercular strictures, is an exceptionally rare entity that can radiologically and clinically mimic gallstone ileus—posing a diagnostic challenge, particularly in tuberculosis-endemic regions.
- They can either be primary or secondary and true or false types.

In this poster, we describe an instance of intestinal obstruction in a middle-aged woman, which was caused by a primary large Enterolith secondary to tubercular stricture.

Case Capsule

A 45-year-old women with prior history of pulmonary tuberculosis presented with classical features of small bowel obstruction (SBO): Colicky abdominal pain, Vomiting, Distention and Obstipation for 3 days

On Per Abdominal Examination

- Abdomen Soft, tenderness noted in umbilicus, Right & left iliac fossa, suprapubic region
- No rigidity, guarding, rebound tenderness, organomegaly noted

Investigation

- Erect Abdominal X-ray suggested a foreign body in the ileum.
- Contrast Enhanced CT(CECT) showed a radiodense lesion in proximal ileum with upstream jejunal dilation & mural thickening of the distal jejunum.

Surgical Management

- Resection of the strictured segment about 42-44cm and end to end ileoileal anastomosis.

- The patient recovered uneventfully and completed one course of ATT drugs.

Intra Operative Finding

- Multiple adhesions between ileum, ceacum and descending colon.
- Multiple brownish green stones around 8-10 noted at distal ileal stricture.
- The gallbladder appeared distended but not fistulized



Figure 1

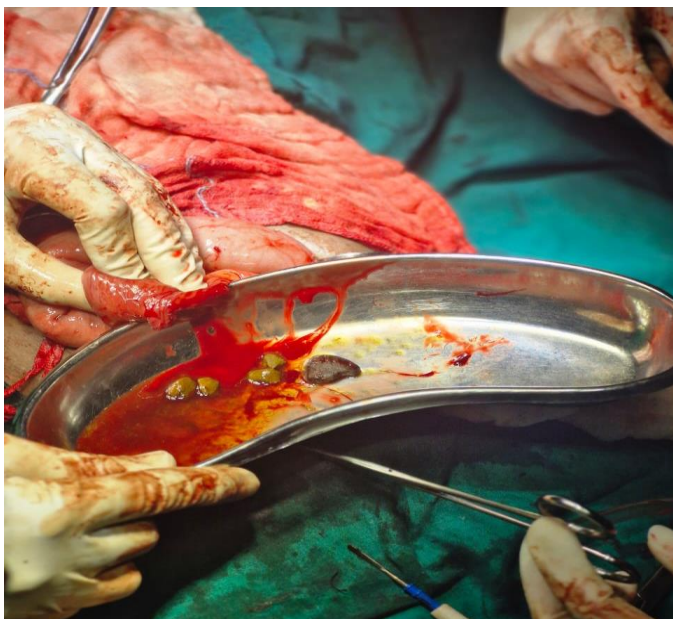


Figure 2

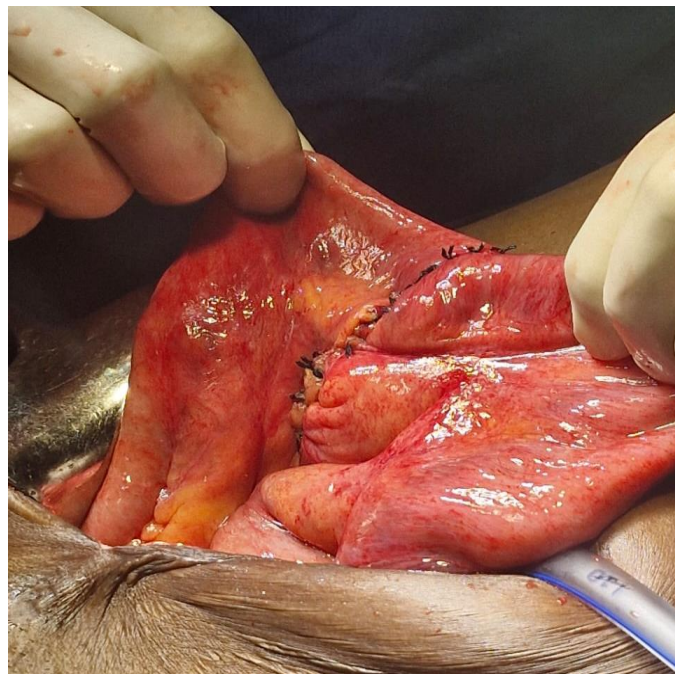


Figure 3

Discussion

- Enterolith ileus incidence ranges from 0.3% to 10%.
- Primary enteroliths typically form in areas of stasis such as strictures, diverticula, blind loops, or adhesions².
- Cholic acid stones form in the proximal bowel while calcium stones occur distally.
- In our case, stone analysis suggested calcium oxalate monohydrate & calcium oxalate dihydrate consistent with primary enteroliths.
- Gallbladder assessment ruled out gallstone ileus due to the absence of a fistula³.
- A history of tuberculosis supports tubercular strictures as the underlying etiology.
- Stones <2 cm may pass spontaneously, while larger stones (>2 cm) require endoscopic or surgical intervention, including stricture dilatation, lithotripsy, enterotomy, or laparoscopy.

Conclusion

- This case underscores the importance of considering enterolith ileus due to intestinal tuberculosis as a

differential diagnosis in SBO, especially in TB-endemic areas.

- Definitive diagnosis relies on intraoperative findings and histopathology.

References

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