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Very rare coincidence: Perforated duodenal ulcer and olive seed phytobezoar

Çok nadir bir birliktelik: Duodenal ülser perforasyonu ve zeytin çekirdeği fitobezoarı

To the Editor,

Ingestion of olive seeds has become very popular among housewives in Turkey following the suggestions of paramedical quack healers seen on television. We present an unusual case of perforated duodenal ulcer (PDU) coinciding with gastric phytobezoar caused by the ingestion of olive seeds, which is extremely rare.

A 43-year-old female patient was operated due to PDU, which coincided with gastric phytobezoar caused by the ingestion of olive seeds. The patient was a housewife with low socioeconomic status living in the city of Ankara. She had suffered from DU for two years and was treated with proton pump inhibitors; she had no known psychiatric disorder. A physical examination revealed rebound tenderness upon palpation. Free air under the diaphragm was visible on the plain abdominal X-ray, but no mass was detected because of the radiolucent olive seeds. On explorative laparotomy, the PDU, huge stomach due to the pyloric stenosis and gastric phytobezoar caused by the ingestion of olive seeds were observed. The stomach was completely filled with olive seeds. At the same time, the site of perforation was found in the distal pyloric stenosis. Therefore, the perforation was independent of the gastric phytobezoar. The gastric phytobezoar was extracted totally by expanding the perforation area (Figure 1). In addition, Judd pyloroplasty and bilateral truncal vagotomy were performed. The postoperative course was uneventful, and the patient was discharged from the hospital on the seventh postoperative day.

A bezoar is an accumulation of ingested foreign material (1,2). The indigestible food fibers form a mass and finally an obstructive ileus. The majority of bezoars are in the stomach. Trichobezoar

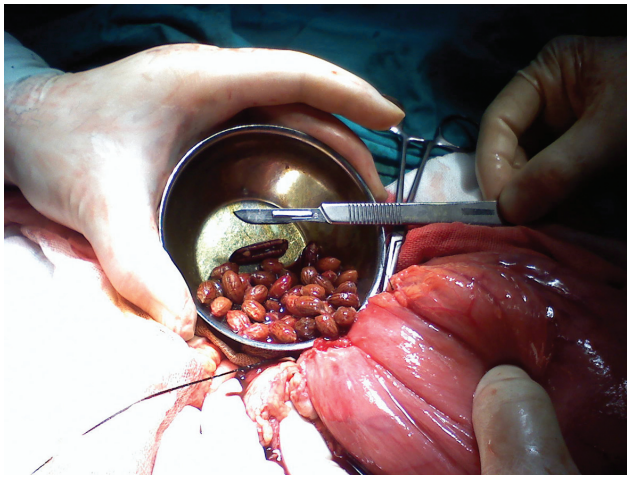

Figure 1. The gastric phytobezoar caused by the ingestion of olive seeds was extracted totally by expanding the perforation area.

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and phytobezoar manifest commonly in young girls with psychiatric disorders. Diagnosis is usually made by computed tomography (CT) scan or ultrasound. Although conservative treatment modalities are described, the surgical approach to a gastric phytobezoar includes extraction of the bezoars with gastrotomy and milking of the bezoar into the small bowel (2-4).

Gastric perforation resulting from trichobezoar (Rapunzel syndrome) is an unusual condition (5), but no reference to the coincidence of PDU and gastric phytobezoar caused by the ingestion of olive seeds was found in the literature. In fact, we were unable to find any reference to gastric phytobezoar caused by the ingestion of olive seeds, with or without perforation. If the patient had had a normal pylorus, the olive seeds could have been digested, as in the case of this patient's husband. Thus, in the case of pyloric stenosis in a patient, ingestion of olive seeds must be strictly forbidden.

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Iatrogenic pneumoscrotum after colonoscopy

Kolonoskopi sonrası iyatrojenik pnömoskrotum

To the Editor,

Colonoscopy is regarded as one of the important procedures in the diagnosis, treatment and follow-up of colorectal lesions. Although the rate of pneumoscrotum is low, this complication can lead to significant morbidity and mortality. Pneumoscrotum is one of the perforation-related complications, and it is extremely rare.

A 70-year-old male patient applied to our clinic with abdominal pain. Colonoscopy was performed for the differential diagnosis of abdominal pain and revealed a 3 cm diverticulum in the sigmoid colon, and the procedure was urgently terminated in order to prevent perforation. The patient described swelling in his neck, face, upper chest, inguinal region, and on the scrotum 3 hours after the procedure. He had diffuse abdominal tenderness on abdominal examination. Computerized tomography of the thorax revealed diffuse air accumulation in the mediastinum, pericardium and in subcutaneous tissues (Figure 1a). Abdominal tomography also showed air accumulation in the scrotal, perirectal, retroperitoneal, and subcutaneous regions (Figure 1b).

He was hospitalized and operated urgently for perforation. During laparotomy, a 3x3 cm diverticulitis and a perforation 1 cm in diameter were de-

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