VEGGIE TRAP: A CASE OF PHYTOBEZOAR IN A VEGETARIAN PATIENT

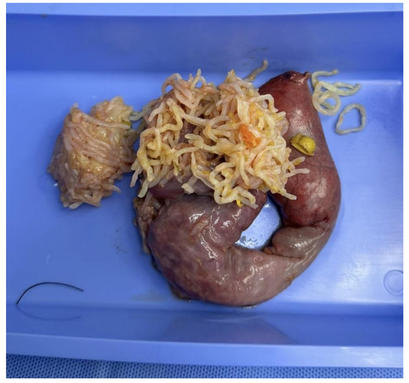
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INTRODUCTION

Phytobezoars are concretions of indigested fruit and vegetable fibers in the gastrointestinal tract. Gastric surgery is the most common risk factor of phytobezoar. We present the case of a 32-year-old male who was admitted to the emergency department with small bowel obstruction due to phytobezoar, he had past medical history of gastric Roux-en-Y gastric Bypass (RYGB) 6 years ago.

CONCLUSIONS

The patient was discharged after 48 hours of hospital stay without complications. The patient was followed monthly, with good results and no abdominal pain. The patient changed his diet with low fiber, proper mastication and treatment of its vegetarian alimentary habits.





CASE PRESENTATION

On clinical examination the patient presented abdominal pain, associated with vomiting and bloating. The procedure started under general balanced anesthesia, patient in modified lithotomy position a transumbilical incision was made and pneumoperitoneum was insufflated with a Veress needle, an 11 mm trocar was placed,under direct vision another two trocars of 5 mm were placed in the right and left paramedial zones, 5 mm trocar placed on the left flank and another 5 mm subxiphoid. Diagnostic laparoscopy is started, showing distended small intestine loops, with good coloration and no signs of necrosis. The gastric pouch was located and the gastrojejunum anastomosis is adequately visualized without alterations. The Peterson space is then searched for, which is observed adequately closed and with no signs of internal hernia. The alimentary loop is followed and an adequate jejunum-jejunum anastomosis is verified without alterations as well as the mesenteric gap with no signs of hernia or ischemia, then it is closed. Subsequently, the small intestine loops are followed until reaching the transition site, which is delimited by a portion of indurated small intestine, which is not mobile, and it is decided to resect a portion of the small intestine using a laparoscopic stapler using two white cartridges. The resected segment is then reconstructed by making an entero-entero anastomosis on a side-to-side basis with a white cartridge and closing the enterotomy with 3-0 Vicryl. The newly formed gap is closed with 2-0 Ethibond and the intestine segment is then extracted, which is explored extracorporeally, revealing an 6/6 alimentary bezoar, which shows food with a hard consistency that completely obstructed the lumen of the small intestine segment. Finally, adequate hemostasis is verified and trocars are extracted under direct vision.