

Mid-Jejunal Bezoar Causing Small Bowel Obstruction in an Adult With Intellectual Disability: A Case Report

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Abstract

Bezoar-induced small-bowel obstruction is an uncommon cause of mechanical intestinal obstruction that may be difficult to diagnose preoperatively because its presentation resembles more common obstructive conditions. We report a 47-year-old woman with intellectual disability and epilepsy who presented with persistent vomiting, poor oral intake, abdominal distension, and cessation of stool and flatus. Computed tomography demonstrated markedly dilated jejunal loops with intraluminal fecalization and a transition region, initially interpreted as likely adhesive obstruction. Exploratory laparotomy identified a transition point in the mid-jejunum, approximately 100 cm distal to the ligament of Treitz, caused by a firm, compact intraluminal mass measuring approximately 7 × 5 cm. The mass was removed through a transverse enterotomy without bowel resection because the bowel remained viable, without evidence of ischemia, necrosis, or perforation. The caregiver reported a habitual tendency to ingest non-food materials, providing a relevant clinical clue, although a formal diagnosis of pica was not established. The postoperative course was uncomplicated, with return of bowel function on postoperative day 2, oral feeding on day 3, and discharge after seven days. At two-week follow-up, the patient remained clinically well. Because the specimen was released to the family and was not subjected to histopathological or chemical analysis, its composition could not be confirmed. This case highlights the importance of caregiver-provided history and consideration of an intraluminal mass in unexplained small-bowel obstruction in patients with intellectual disability.

Categories: Radiology, General Surgery, Gastroenterology

Keywords: bezoar, intellectual disability, jejunum, pica, small bowel obstruction

Introduction

Bezoars are uncommon gastrointestinal masses composed of indigestible material accumulated within the gastrointestinal tract. They are classified according to their composition, with phytobezoars being the most common type [1]. Although bezoars may remain asymptomatic, small-intestinal involvement is clinically important because an impacted bezoar can produce mechanical obstruction and require urgent endoscopic or surgical treatment [2]. Bezoars have been estimated to account for approximately 0.4% to 4% of mechanical intestinal obstructions, although their true incidence remains uncertain [3].

The jejunum is an important site of bezoar impaction. In a retrospective study of 62 patients with intestinal obstruction due to bezoars, the jejunum was the most frequent location, accounting for 45.1% of cases [4]. Similarly, Kim et al. (2003) [5] identified jejunal involvement in 63% of patients with phytobezoar-associated small-bowel obstruction. Despite this, preoperative recognition can be difficult because the clinical manifestations of bezoar-induced obstruction are nonspecific and may closely resemble those of more common causes of mechanical obstruction [6]. Computed tomography (CT) is valuable for identifying the level and nature of obstruction, with reported features including dilated bowel loops and an intraluminal mass containing mottled gas or entrapped air bubbles [5,7]. However, these characteristic findings may not always lead to recognition of the bezoar as the underlying cause, particularly when the relevant clinical or behavioral history is unavailable.

The possibility of bezoar formation may be particularly relevant in individuals with intellectual disability who exhibit abnormal ingestion behaviors. Pica, defined as repeated ingestion of non-food substances, has been associated with intellectual disability and can lead to serious medical and gastrointestinal complications [8,9]. Reported prevalence of pica has ranged from 9% to 25% among institutionalized populations, while a multisite study reported pica in 9.7% of children with developmental disabilities and intellectual disability and 28.1% of those with autism spectrum disorder and intellectual disability [8,9]. Thus, when evaluating unexplained intestinal obstruction in a patient with intellectual disability, information from caregivers regarding abnormal ingestion may provide an important diagnostic clue.

The present case describes mechanical mid-jejunal obstruction caused by a large intraluminal mass grossly

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consistent with a bezoar in an adult with intellectual disability and caregiver-reported non-food ingestion behavior, without previous abdominal surgery or known gastrointestinal disease. The case illustrates the diagnostic challenge posed by limited clinical history and the difficulty of identifying the specific cause of obstruction before surgery. Because the extracted specimen was not analyzed, its composition could not be confirmed, and the reported ingestion behavior did not establish a formal diagnosis of pica. The case therefore emphasizes the value of caregiver-provided history and careful assessment of unexplained small-bowel obstruction while acknowledging the limitations of gross specimen characterization.

Case Presentation

A 47-year-old woman residing in a social care facility, with a history of intellectual disability and epilepsy, was referred to our hospital with persistent vomiting for two days. History-taking was limited because the patient could not provide reliable information, and the accompanying caregiver had incomplete knowledge of her medical history. According to the caregiver, the patient had been in her usual state of health until approximately two days before presentation, when she developed recurrent vomiting, with approximately seven episodes in total. The vomitus was described as projectile, greenish-yellow, and foul-smelling, with a feculent odor. Her oral intake had markedly decreased since the preceding day. No diarrhea was reported, and further review of systems could not be reliably obtained.

Her medical history was significant for intellectual disability and epilepsy, treated with levetiracetam 500 mg twice daily. She had no history of abdominal surgery, previous intestinal obstruction, known gastrointestinal disease, endoscopy, or gastric surgery. Her usual bowel habits were regular, with approximately two bowel movements daily. There was no reported history of chronic constipation, excessive fiber or vegetable intake, or dental or mastication problems. The caregiver reported that the patient had a habitual tendency to ingest objects or non-food materials placed in front of her. The patient was residing in a social care facility and was under the care of its medical and psychiatric teams. No previous ingestion episodes requiring medical attention were reported; however, the available history and records did not provide reliable details regarding the specific materials previously ingested, the timing or frequency of these behaviors, any previous ingestion-related treatment, or whether specific counseling had been provided. No formal diagnosis of pica had been established.

On examination, the patient was conscious and at her baseline level of consciousness. Her vital signs were as follows: heart rate, 63 beats/min; blood pressure, 115/61 mmHg; respiratory rate, 18 breaths/min; temperature, 37.8°C; and oxygen saturation, 92%. The abdomen was distended, with hyperactive bowel sounds, but remained soft and lax, without tenderness, guarding, or rigidity. No palpable abdominal mass or hernia was identified, and there were no previous surgical scars. Digital rectal examination revealed normal anal tone, with no stool in the rectum. The caregiver reported that the patient had not passed stool or flatus for approximately four days before surgery. The exact onset of obstipation relative to the onset of vomiting could not be reliably established from the available history.

Initial laboratory investigations showed mild hyponatremia, decreased creatinine and lipase levels, and increased urea and gamma-glutamyl transferase (GGT) levels relative to the reference intervals presented in Table 1. Venous blood gas analysis showed a mildly increased pH and a PCO₂ value below the reference interval used in the table, whereas bicarbonate and lactate were within their stated reference ranges. These isolated findings did not establish a specific acid-base disorder. The remaining reported hematological, inflammatory, biochemical, hepatic, pancreatic, and coagulation parameters were within their respective reference ranges, and troponin was negative (Table 1).

Laboratory parameter	Patient value	Reference range	Interpretation
Hemoglobin, g/dL	13.3	12.0–16.0	Within range
White blood cell count, $\times 10^3/\mu\text{L}$	8.9	4.0–11.0	Within range
Platelet count, $\times 10^3/\mu\text{L}$	411	150–450	Within range
Sodium, mmol/L	134	135–145	Decreased
Potassium, mmol/L	3.5	3.5–5.1	Within range
Creatinine, mg/dL	0.5	0.6–1.1	Decreased
Urea, mmol/L	10.7	2.5–7.1	Increased
C-reactive protein, mg/L	3	<5	Within range
Lactate, mmol/L	1.7	0.5–2.2	Within range
Amylase, U/L	69	30–110	Within range
Lipase, U/L	5	13–60	Decreased
Aspartate aminotransferase, U/L	26	10–40	Within range
Alanine aminotransferase, U/L	12	7–56	Within range
Gamma-glutamyl transferase, U/L	126	9–48	Increased
Total bilirubin, mg/dL	0.4	0.2–1.2	Within range
Direct bilirubin, mg/dL	0.2	0–0.3	Within range
International normalized ratio	1.1	0.8–1.2	Within range
Prothrombin time, s	13.3	11–14	Within range
Activated partial thromboplastin time, s	30.4	25–35	Within range
Venous pH	7.44	7.31–7.41	Increased
Venous PCO_2 , mmHg	39	41–51	Decreased
Venous HCO_3^- , mmol/L	25.6	22–29	Within range
Troponin	Negative	Negative	Within expected range

TABLE 1: Initial laboratory investigations at presentation

Laboratory investigations obtained at initial presentation before operative intervention. Values are presented with the corresponding reference ranges. "Increased" and "decreased" indicate values above or below the stated reference range, respectively. PCO_2 , partial pressure of carbon dioxide; HCO_3^- , bicarbonate.

Contrast-enhanced computed tomography (CT) of the abdomen and pelvis demonstrated markedly dilated jejunal loops measuring approximately 4 cm in diameter, with small-bowel fecalization and a transition region in the upper abdomen, followed by collapse of the distal ileal loops and colon. There was no abnormal bowel-wall enhancement, pneumatosis intestinalis, or extraluminal gas, and the major abdominal vessels were patent. The findings were consistent with mechanical small-bowel obstruction, initially considered likely to be secondary to adhesions. Additional findings included chronic calculous cholecystitis, mild abdominopelvic free fluid, bilateral basal pulmonary atelectatic changes, and a hypoenhancing focal lesion in segment VI of the right hepatic lobe requiring further evaluation. The initial oxygen saturation of 92%, temperature of 37.8°C, increased GGT level, and hepatic lesion were documented; however, the available records did not establish their underlying causes or confirm whether further respiratory, biochemical, or hepatic evaluation was undertaken. The CT findings are illustrated in Figure 1, with annotations identifying the dilated proximal bowel, transition region, and relatively collapsed distal bowel.

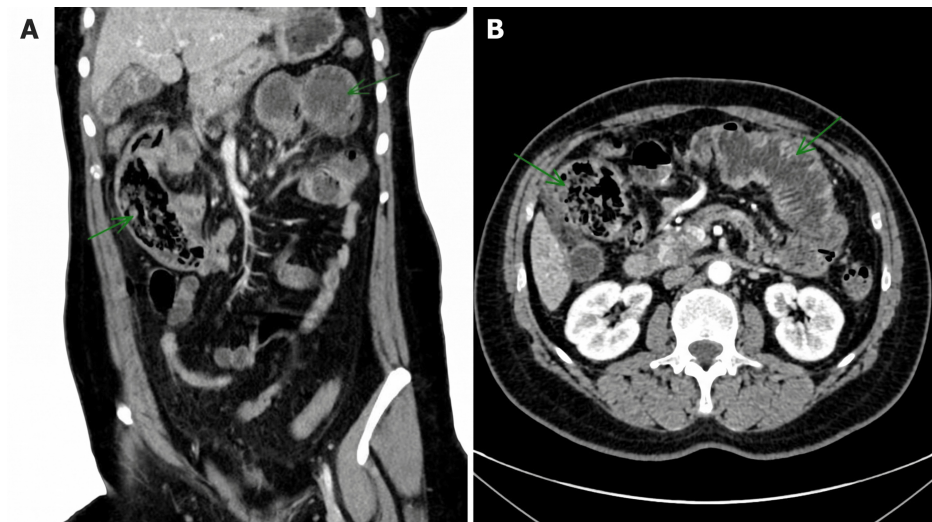


FIGURE 1: Contrast-enhanced computed tomography demonstrating jejunal small-bowel obstruction

(A) Coronal and (B) axial contrast-enhanced CT images demonstrating markedly dilated proximal jejunal loops with small-bowel fecalization and a transition point in the upper abdomen, with relative collapse of the distal small bowel and colon. Green arrows indicate the dilated bowel loops and transition region. No CT features of bowel ischemia, pneumatosis intestinalis, or perforation were identified.

The patient was initially managed with bowel rest, nasogastric decompression, and intravenous fluid therapy. Following review of the CT images with an experienced radiologist, the transition region was considered to correspond to a large intraluminal mass causing complete mechanical obstruction. A limited midline laparotomy was selected rather than an initial laparoscopic approach to permit direct assessment of bowel viability and facilitate removal of the large, firm obstructing mass through an enterotomy. The surgical team considered that an initial laparoscopic approach might necessitate conversion to an open procedure, potentially prolonging operative time. This decision was based on the anticipated operative requirements in this individual case.

Exploratory laparotomy was performed under general anesthesia through a midline incision of approximately 5 cm. Systematic examination of the small bowel identified a transition point in the mid-jejunum, approximately 100 cm distal to the ligament of Treitz and approximately 300 cm proximal to the ileocecal valve. The proximal bowel was markedly dilated, measuring approximately 4-5 cm in diameter, with a clear transition to collapsed distal bowel. The bowel remained viable, with no evidence of ischemia, necrosis, or perforation. No intra-abdominal adhesions were identified, and no additional obstructing masses were found. The intraoperative appearance of the dilated bowel and transition region is shown in Figure 2.



FIGURE 2: Intraoperative appearance of the obstructed small bowel

The photograph demonstrates markedly dilated proximal small-bowel loops with prominent serosal congestion and a clear transition from dilated to collapsed bowel segments. The bowel was viable, with no gross evidence of ischemia, necrosis, or perforation. Exploration revealed no intra-abdominal adhesions or additional obstructing bezoars.

At the transition point, a firm, compact, irregular intraluminal mass measuring approximately 7×5 cm was identified as the cause of obstruction. A transverse enterotomy of approximately 4 cm was made immediately proximal to the obstruction, and the mass was completely extracted. The enterotomy was closed transversely. No bowel resection was required. Hemostasis was secured, no drain was placed, and no intraoperative complications occurred. Estimated blood loss was approximately 200 mL.

The extracted mass was dark brown, heterogeneous, firm, and compact. Based on its gross appearance, intraluminal location, obstructive effect, and the caregiver-reported ingestion behavior, it was considered grossly consistent with a bezoar. The specimen measured approximately 7×5 cm and is shown in Figure 3. At the family's request, the specimen was released to them in accordance with hospital policy regarding the release of removed foreign materials. Consequently, it was not retained for histopathological, microscopic, or chemical analysis, and its exact composition could not be confirmed. The diagnosis was therefore recorded as mechanical mid-jejunal obstruction caused by an intraluminal mass suspected to represent a bezoar.

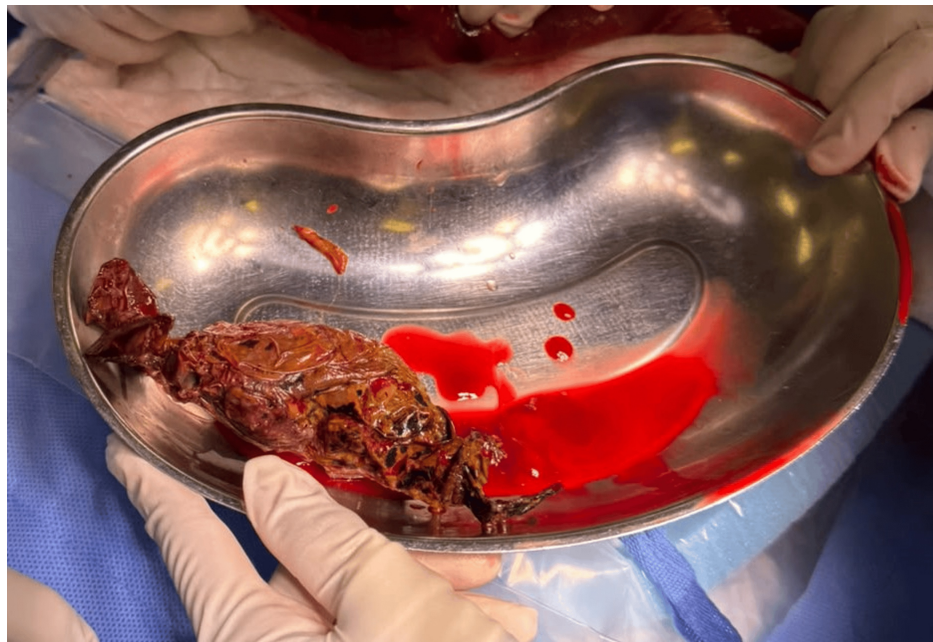


FIGURE 3: Gross appearance of the extracted jejunal bezoar

The photograph demonstrates a large, irregular, compact, dark-brown intraluminal mass extracted from the mid-jejunum at the site of mechanical obstruction. The mass measured approximately 7×5 cm and had a firm, heterogeneous appearance. No histopathological or chemical analysis was performed; therefore, its exact composition could not be confirmed.

The postoperative course was uncomplicated. Bowel sounds returned on postoperative day 2, when the patient also passed stool and flatus. Oral feeding was initiated on postoperative day 3 and was tolerated. The surgical wound remained clean and dry, and no postoperative complications were documented. The patient was discharged after a total hospital stay of seven days in an improved clinical condition. At the two-week follow-up, she remained clinically well, without recurrent vomiting or other symptoms suggestive of recurrent intestinal obstruction.

Discussion

Bezoar-induced small-bowel obstruction is an uncommon but clinically important cause of mechanical intestinal obstruction, and its diagnosis may be challenging because its presentation overlaps with more common causes of obstruction. Bezoars account for approximately 0.4% to 4% of mechanical intestinal obstruction [3,10]. In the present case, persistent vomiting, abdominal distension, and cessation of stool and flatus were associated with CT evidence of mechanical small-bowel obstruction. However, the initial radiological impression favored adhesive obstruction, and the obstructing intraluminal mass was identified only during surgery. Because the extracted specimen was not analyzed, the diagnosis of a bezoar remains presumptive rather than composition-confirmed.

The mid-jejunal location is an important feature of this case. In a retrospective series of 62 patients with intestinal obstruction due to bezoars, the jejunum was the most frequent location, accounting for 45.1% of cases [4]. Similarly, Kim et al. (2003) [5] reported jejunal involvement in 63% of patients with phytobezoar-associated small-bowel obstruction. Previous case reports have also described jejunal bezoars causing acute obstruction, including a primary bezoar associated with a jejunal diverticulum and simultaneous gastric and jejunal bezoars [11,12]. The present case is consistent with these reports in demonstrating an intraluminal jejunal mass producing mechanical obstruction. However, it differs in that the patient had no previous abdominal surgery or known gastrointestinal disease, and no intra-abdominal adhesions were identified at exploration. The mass was located approximately 100 cm distal to the ligament of Treitz and measured approximately 7×5 cm, producing marked proximal jejunal dilatation. These findings illustrate how an intraluminal lesion may cause significant obstruction even in a patient without the usual clinical history of postoperative adhesions.

The patient's intellectual disability and habitual ingestion of non-food materials provide an important additional diagnostic clue. Pica has been associated with intellectual disability and may cause serious gastrointestinal complications [8,9]. A previously reported case of plastic bezoar-induced small-bowel obstruction involved a young adult with autism and intellectual disability who had behavioral problems and was non-verbal [13]. Similarly, Mejri and Trigui (2021) [14] reported jejunal bezoar obstruction in a patient with intellectual disability. In the present case, however, the caregiver's report did not establish a formal

diagnosis of pica or prove the composition of the obstructing mass. Furthermore, detailed information regarding previous ingestion episodes, the materials involved, and any ingestion-specific treatment or counseling could not be reliably obtained. The reported behavior should therefore be interpreted as a clinical clue rather than evidence of a confirmed behavioral diagnosis or a proven causal relationship. Collateral history from caregivers may nevertheless be particularly valuable when patients cannot reliably communicate their medical or behavioral history.

CT is valuable for determining the level and severity of bezoar-induced obstruction, but identifying the bezoar itself may remain difficult. Previous studies have described dilated bowel loops with an intraluminal mass containing mottled gas or entrapped air bubbles as characteristic findings [5,7]. CT may also demonstrate bowel-wall and vascular changes relevant to management [15]. In the present case, CT showed jejunal dilatation of approximately 4 cm, small-bowel fecalization, a transition region, and collapse of the distal bowel. Nevertheless, the underlying intraluminal mass was not definitively recognized before surgery, and the initial interpretation favored adhesive obstruction. The limited behavioral history available before surgery may have contributed to the diagnostic uncertainty. This case illustrates that imaging can establish mechanical obstruction without necessarily establishing its precise etiology, particularly when the characteristic appearance of an intraluminal mass is not clearly recognized.

Bezoars are classified according to their predominant composition. Phytobezoars consist mainly of indigestible plant material, trichobezoars are composed of hair, and pharmacobezoars consist of aggregated medications or pharmaceutical substances [1,2]. Other intraluminal masses may contain miscellaneous indigestible materials. Treatment depends on the location, composition, size, and consistency of the mass, the degree of obstruction, and the presence of complications. Selected gastric bezoars may be managed with endoscopic fragmentation or extraction, while dissolution therapy may be considered for certain phytobezoars in appropriate clinical circumstances [1,2]. Conservative management may be considered in carefully selected, clinically stable patients without evidence of bowel compromise, provided that close monitoring is feasible. In contrast, persistent mechanical obstruction, clinical deterioration, or suspected ischemia or perforation warrants urgent surgical assessment. The composition of the mass in the present case could not be determined, and it therefore cannot be assigned to a specific bezoar subtype.

The surgical approach in this case was selected after review of the CT images with an experienced radiologist, who considered the transition region to correspond to a large intraluminal mass causing complete mechanical obstruction. A limited midline laparotomy was chosen to permit direct assessment of bowel viability and facilitate extraction of the firm, compact mass through an enterotomy. The team considered that an initial laparoscopic approach might require conversion to open surgery, potentially prolonging operative time. This decision reflected the anticipated operative requirements in this individual patient and should not be interpreted as evidence that laparoscopy is unsuitable for other cases of small-bowel obstruction. In the series reported by Altintoprak et al. [4], enterotomy was used in 37% of cases, while milking was performed in 41.9%. In the present case, the mass was removed through a transverse enterotomy without bowel resection because the bowel remained viable and showed no gross evidence of ischemia, necrosis, or perforation. No additional obstructing masses or intra-abdominal adhesions were identified. Although additional bezoars have been reported at other gastrointestinal sites [12,14], this case does not establish their frequency or justify assumptions about their presence in other patients.

An important limitation is that the extracted mass was not subjected to histopathological, microscopic, or chemical analysis. At the family's request, the specimen was released in accordance with hospital policy regarding the release of removed foreign materials. Consequently, its exact composition could not be established. The gross appearance, intraluminal location, obstructive effect, and caregiver-reported ingestion behavior supported a suspected bezoar, but they did not establish a specific material or bezoar subtype. The patient's reported behavior also did not establish a formal diagnosis of pica. These limitations should be considered when interpreting the proposed etiology. In addition, clinical follow-up was limited to two weeks, and subsequent evaluation of the incidental hepatic lesion and elevated gamma-glutamyl transferase level could not be confirmed from the available records.

The postoperative course was uncomplicated, with return of bowel function on postoperative day 2, initiation of oral feeding on day 3, and discharge after seven days. No recurrent obstructive symptoms were reported at the two-week follow-up. These findings document a favorable short-term outcome following removal of the obstructing mass, although the short follow-up period does not establish long-term freedom from recurrence. Overall, this case illustrates the diagnostic challenges associated with unexplained jejunal obstruction in a patient with intellectual disability and limited history. Integration of caregiver-provided information, radiological findings, and operative assessment may assist clinical decision-making when the cause of obstruction remains uncertain. The experience also emphasizes the importance of documenting specimen handling and acknowledging the limitations of gross characterization when laboratory analysis is unavailable.

Conclusions

Bezoar-induced small-bowel obstruction is an uncommon cause of mechanical intestinal obstruction that may be difficult to diagnose preoperatively. This case illustrates the diagnostic challenges of mid-jejunal

obstruction in an adult with intellectual disability and caregiver-reported non-food ingestion behavior. Although this history provided a relevant clinical clue, neither a formal diagnosis of pica nor the composition of the obstructing mass could be confirmed. The case highlights the value of integrating caregiver-provided history with radiological and operative findings when evaluating unexplained intestinal obstruction. In this patient, a limited laparotomy and enterotomy enabled removal of the obstructing mass without bowel resection. However, the findings from a single case do not establish a universally preferred surgical approach. The possibility of additional bezoars may also be considered during surgical exploration when clinically appropriate. When feasible, analysis of the extracted material can help establish its composition and facilitate more definitive classification.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

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Disclosures

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