EJCRIM
European Journal
of Case Reports
in Internal Medicine

ENDOSCOPIC SALVAGE OF COLONIC OBSTRUCTION CAUSED BY AN UNIDENTIFIED FIBROUS FOREIGN BODY

Mohammed Y. Youssef[1], Isabella Bortolussi[1], Mohamed H. Eldesouki[2], Hafsa Khan[1], Asim Usman[1], Jaison John[1]

[1] Internal Medicine Department, Arkansas Colleges of Health Education, Fort Smith, USA
[2] Department of Internal Medicine, New York Medical College at Saint Michael's Medical Center, Newark, USA

Corresponding author's e-mail: Mohammedyoussef96@yahoo.com

Received: 12/02/2026
Accepted: 09/06/2026
Published: 07/04/2026

Conflicts of Interests: The Authors declare that there are no competing interests.
Patient Consent: Informed consent was obtained from the patient for the publication of this case report and any accompanying images; a copy of the written consent is available for review upon request.
Acknowledgments: Publication fees for this article were supported by the Arkansas Colleges of Health Education Library Open Access Fund.
This article is licensed under a Commons Attribution Non-Commercial 4.0 License

How to cite this article: Youssef MY, Bortolussi I, Eldesouki MH, Khan H, Usman A, John J. Endoscopic salvage of colonic obstruction caused by an unidentified fibrous foreign body. *EJCRIM* 2026;**13**:doi:10.12890/2026_006297

ABSTRACT

Introduction: There is a large variety of intestinal foreign bodies, including sex toys, produce, and glass, and management depends on the object's composition and location. We present a case of a fibrous foreign body causing complete colonic obstruction that was successfully treated using a novel balloon-assisted technique.

Case description: A 30-year-old woman with no significant medical history presented with abdominal pain, constipation, nausea, and vomiting. Computed tomography (CT) imaging demonstrated a large faecal burden in the proximal colon with mucosal thickening and obstruction from a presumed fixed mass in the left colon. Colonoscopy revealed a foreign body completely occluding the descending colon lumen. Initial removal attempts using nets, snares, and grasping devices were unsuccessful, and surgery was consulted for possible hemicolectomy. In a final effort to avoid surgery, a 20 mm through-the-scope balloon dilator was advanced blindly through the fibrous obstruction. The balloon was inflated and retracted toward the colonoscope to fragment and sweep debris. Repeated passes removed substantial fibrous material. Mineral oil lavage was administered to lubricate the lumen and facilitate debris passage. The patient subsequently received 2 litres of polyethylene glycol. Repeat CT imaging showed near-complete resolution of obstruction. Pathology demonstrated acellular fibrous material with inflammatory cells.

Discussion: Foreign body ingestion is common, yet refractory colonic impactions lack standardized management. This case demonstrates that balloon-assisted sweeping with adjunctive lavage can provide a safe, surgery-sparing alternative for complex colonic foreign body obstruction.

KEYWORDS

Colonic foreign body impaction, endoscopic balloon dilation, large bowel obstruction

EFIM
European Federation of Internal Medicine

Publisher
smc media srl

LEARNING POINTS

- Introduces a practical, surgery-sparing endoscopic strategy combining balloon sweeping and lubrication to successfully relieve a complete colonic obstruction after failure of conventional retrieval tools.
- Provides internists with an actionable escalation pathway for refractory large bowel foreign body impactions, potentially preventing hemicolectomy and reducing morbidity in otherwise stable patients.
- *Highlights a strategic multi-modal treatment algorithm:* the work showcases a comprehensive management approach—combining mechanical fragmentation, chemical lubrication with mineral oil, and post-procedural osmotic laxatives—to resolve high-grade colonic obstructions safely and completely.

INTRODUCTION

Foreign bodies (FB) ingestion is a common presentation in emergency departments across all age groups. In adults, most cases of FB ingestion are intentional and involve intoxication, psychiatric illness, or incarceration[1]. FB ingestion can lead to a wide variety of symptoms, ranging from asymptomatic to colonic obstruction and perforation depending on the location and duration of impaction, The nature and timing of complications depend on the object's characteristics (size, shape, consistency), its anatomical location, and how long it remains undetected[2]. While the majority silently pass through the gut (80-90%), some become impacted at various points in the alimentary tract. Sharp or elongated items such as fish bones, chicken bones, toothpicks, or glass increase the risk of obstruction, perforation, abscess or fistula formation, especially when they reach the large bowel[3].

We present a rare case of FB impaction in the large bowel with total occlusion of the colon in an otherwise healthy lady.

CASE DESCRIPTION

A 30-year-old female with no significant past medical history presented to the emergency department with a 2-day history of a severe, stabbing pain in the left upper quadrant that radiated diffusely across the entire abdomen. Additionally, she complained of anorexia and a notable decrease in stool production with mild haematochezia. Physical exam of the abdomen demonstrated tenderness to palpation and mild abdominal distension. Lab work showed microcytic anaemia without history of menorrhagia or other causative factors. A computed tomography (CT) scan of the abdomen and pelvis with contrast showed copious amounts of faeces in the proximal colon along with submucosal thickening and narrowing of a long segment in the descending colon as well as some adjacent ascites. These findings appeared to be caused by an obstruction in

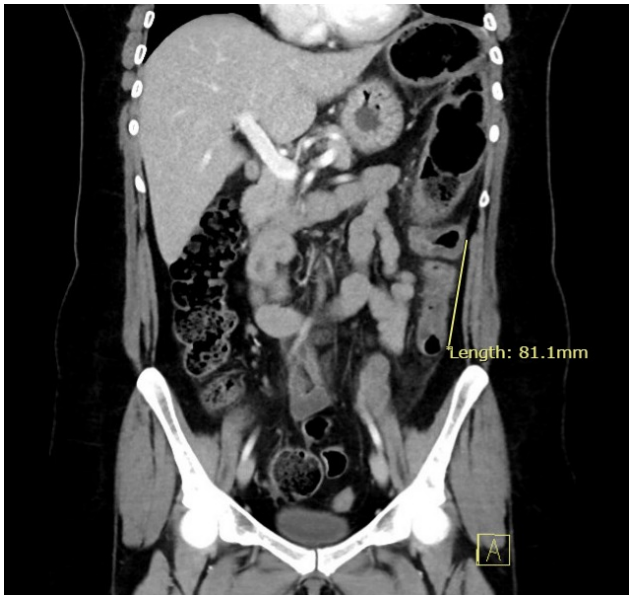


Figure 1. Coronal computed tomography image showing an 81 mm elongated foreign body impacted in the proximal descending colon with associated wall thickening and partial obstruction.

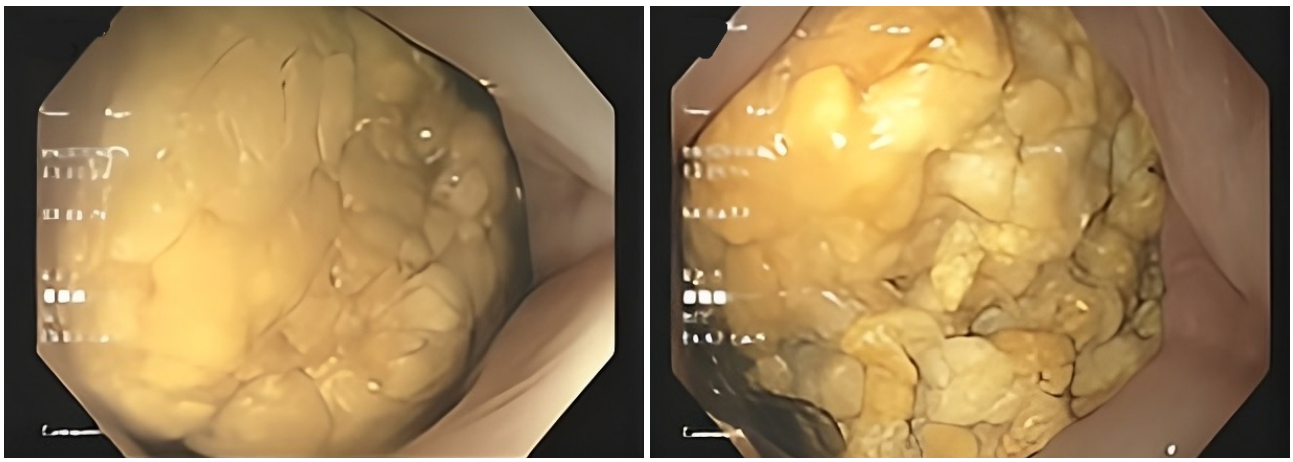


Figure 2. Colonoscopy images showing a compacted foreign body causing complete obstruction.

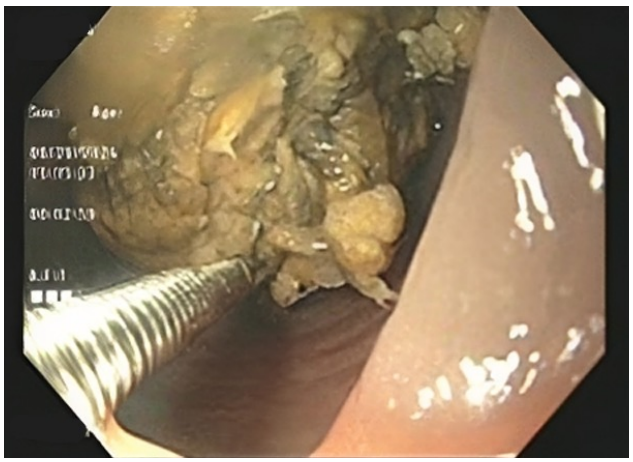


Figure 3. Rat tooth grasper attempting to slowly disimpact with no significant improvement.

the proximal descending colon from a presumed fixed mass *(Fig. 1)*. Gastroenterology was consulted and the patient was started on IV hydration and prepped for colonoscopy with two enemas. Colonoscopy revealed a 10 cm-long tightly compressed FB completely occluding the lumen of the proximal descending colon *(Fig. 2)*. Attempts for removal with nets, and graspers were unsuccessful *(Fig. 3)*. The bezoar was suspected to be undigested food versus unspecified fibrous material. General surgery was consulted for possible hemicolectomy but ultimately one more retrieval attempt was made via flexible sigmoidoscopy. The FB was again visualized beginning in proximal descending colon. An unusual approach was taken by advancing a balloon dilator beyond the impaction and sequentially inflating and sweeping debris towards the colonoscope. Removal of solid debris was accomplished with blindly pushing a 15 mm, 16.5 mm, 18 mm, then finally a 20 mm balloon dilator through the scope and fibrous obstruction *(Fig. 4A and B)*. The FB was visualized in the proximal descending colon, splenic flexure, and the mid transverse colon as well as mucosal ulceration at the splenic flexure. Repeated attempts resulted in significant removal of large pieces of fibrous debris leading to improved luminal clearance *(Fig. 4C)*. The lumen of the colon was then generously lavaged with a moderate amount of mineral oil to allow for lubrication and to aid in subsequent passage of the debris. After colonoscopy the patient was given 2 litres of polyethylene glycol leading to multiple bowel movements. Repeat CT scan of the abdomen and pelvis with contrast showed no findings suggestive of obstruction. Pathology of the retrieved material revealed acellular, fibrous material with inflammatory cells.

DISCUSSION

FB impaction in the colon is an uncommon clinical entity, given the large size of the colon, it allows for passage of materials, and FB usually impacts in the narrower small bowel[4]. Imaging, in particular CT, is usually the modality of choice for the diagnosis and localization of the FB impaction and the associated complications[5]. To date, there is no standardized or high-level evidence regarding the optimal management strategy for impacted FB in the colon[6]. While the use of balloon dilators and lavages are not independently unique techniques in colonoscopies, the use of them together with the intention of clearing an ingested obstruction is distinct. Balloon dilators are commonly used during the treatment of benign strictures like those that develop with Crohn's disease or stenosis of anastomoses that develop postoperatively[7]. Comparatively, the use of mineral oil lavage is commonly used to help pass the colonoscope more comfortably for the patient, not necessarily to help flush out adherent debris[8]. This case shows that the combination of balloon dilators to sweep clear or dislodge an obstruction with the use of mineral oil lavages with the intent to help the patient further pass residual adherent obstruction material should be further considered. Additional success of this procedure can be attributed to the use of polyethylene glycol post-procedurally to help prevent recurrence.

While FB ingestions are commonly encountered by gastroenterologists there are limited tools available to aid in clearance of these objects, especially when they are exceptionally adherent and difficult to clear. This case highlights a unique endoscopic intervention using balloon dilation and lavage with mineral oil as an alternative to surgery in the management of colonic obstruction due to FB impaction.

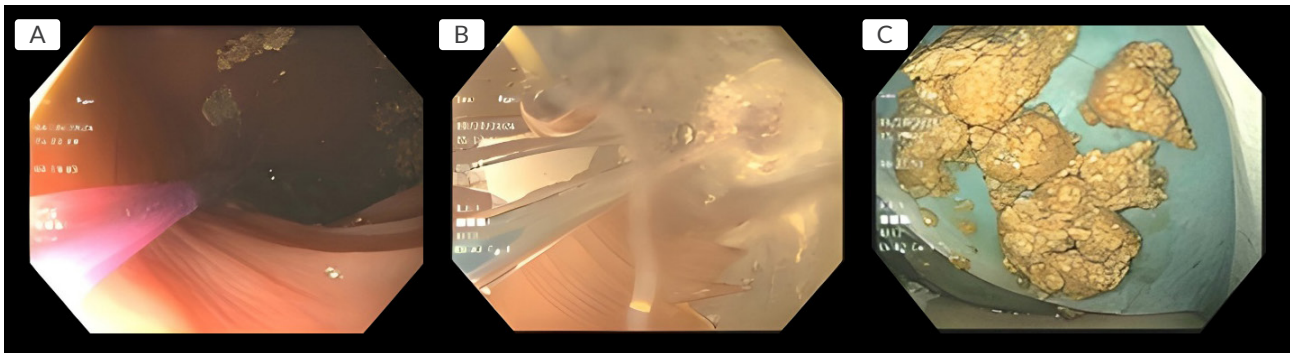


Figure 4. A-B) Balloon device being pushed past obstruction and inflated; C) Debris cleared out.

REFERENCES

1. Tambakis G, Schildkraut T, Delaney I, Gilmore R, Loebenstein M, Taylor A, et al. Management of foreign body ingestion in adults: Time to STOP and rethink endoscopy. *Endosc Int Open* 2023;11:E1161-E1167. doi: 10.1055/a-2201-6928
2. Jaan A, Mulita F. Gastrointestinal Foreign Body. [Updated 2023 Aug 28]. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025 Jan-
3. Erbil B, Karaca MA, Aslaner MA, Ibrahimov Z, Kunt MM, Akpinar E, et al. Emergency admissions due to swallowed foreign bodies in adults. *World J Gastroenterol* 2013;**19**:6447-6452. doi: 10.3748/wjg.v19.i38.6447
4. Hu T, Zhang J, Liu Y, Chen L, Cen W, Wu W, et al. Evaluation of the risk factors for severe complications and surgery of intestinal foreign bodies in adults: a single-center experience with 180 cases. *Gastroenterol Rep (Oxf)* 2022;**10**:goac036. doi: 10.1093/gastro/goac036
5. Jaan A, Mulita F. Gastrointestinal Foreign Body. [Updated 2023 Aug 28]. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025 Jan-.
6. ASGE Standards of Practice Committee; Ikenberry SO, Jue TL, Anderson MA, Appalaneni V, Banerjee S, et al. Management of ingested foreign bodies and food impactions. *Gastrointest Endosc* 2011;73:1085-1091. doi: 10.1016/j.gie.2010.11.010
7. Chan RH, Lin SC, Chen PC, Lin WT, Wu CH, Lee JC, et al. Management of colorectal anastomotic stricture with multidiameter balloon dilation: long-term results. *Tech Coloproctol* 2020;**24**:1271-1276. doi: 10.1007/s10151-020-02318-2
8. Harrison NM, Hjelkrem MC. Bowel cleansing before colonoscopy: Balancing efficacy, safety, cost and patient tolerance. *World J Gastrointest Endosc* 2016;**8**:4-12. doi: 10.4253/wjge.v8.i1.4