An 83-year-old man presented to our clinic with diffuse abdominal pain for 6 h. Physical examination revealed diffuse abdominal tenderness with muscle guarding, especially in left lower quadrant. Laboratory tests showed leukocytosis with 88% neutrophils. Computed tomography (CT) scan showed perforated jejunum by a 2.5 cm high-density linear opacity without apparent pneumoperitoneum or focal mesenteric fat inflammation (Figure 1, white arrow). Exploratory laparotomy confirmed jejunum penetrated by the fish bone (Figure 1, black arrow). The post-operative recovery was uneventful. Our patient’s case shows early presentation of bowel perforation due to fish bone ingestion without thickened intestinal segment, localized pneumoperitoneum, regional fatty infiltration or associated intestinal obstruction. The only hint of intestinal perforation on CT scan was a linear calcified lesion penetrating the bowel wall.

Small bowel perforation was known as a rare cause of acute abdomen with an incidence of 1 in 300–350,000. The site of perforation often occurs at narrow lumen or angulated area such as distal ileum, ileocecal valve and rectosigmoid junctions. The perforation located at jejunum is relatively rare but presented in our case. CT scan in diagnosed GI perforation is very sensitive, reliable and superior to plain film in displaying intra- and extra-peritoneal air. In addition, identification of the foreign bodies from CT scan by the clinician can achieve the definitive diagnosis. CT scan is a reliable modality for GI perforation which provides the clinician the presence, level and cause of perforation. The perforated bowel should be managed by surgery urgently with antibiotic therapy. In the case of suspect GI perforation, image studies should be performed after taking detail history and physical exam. CT is a reliable modality for GI perforation and provides the clinician the presence, level and cause of perforation.

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