Case Report

CHOLECYSTO Gastric FISTULA: 
AN UNUSUAL PRESENTATION

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ABSTRACT

We are presenting a rare case of cholecystogastric fistula, which presented as chronic cholecystitis and obstructive jaundice (Rawal Med J 2006;31:44-45).

Key Words: Cholecystitis, fistula, cholecystectomy

INTRODUCTION

Biliary fistulas are either external or internal. External fistulas are not very common as compared to internal. The mode of presentation of the fistulas varies depending upon the type of fistula. Internal fistulas are usually spontaneous and arise from chronic or acute perforation of the gall bladder or malignant infiltration into adjacent organs. In addition, abnormal biliary tract connections have been reported into the kidney, urinary bladder, uterus, vagina, portal vein, inferior vena cava and pericardial sac.¹
CASE REPORT

A 38 years old lady, diabetic and diagnosed as a case of cholelithiasis for last two years, presented with four days history of epigastric pain, yellowish discoloration of sclera, pruritis, dark color urine and clay color stools. Past history was not significant. On physical examination, she was jaundiced. Vital signs were stable. Ultrasound abdomen revealed normal liver, slight enlargement of spleen, thick walled gall bladder with multiple calculi with normal caliber of common bile duct (CBD). Her liver function tests showed total bilirubin 71 µmol/L (direct: 45µmol/L), alanine transaminase 77 u/L, alkaline phosphatase 696 u/L and serum amylase 147 u/L. An ERCP showed normal papilla, moderately dilated CBD, and gas in intrahepatic biliary channels and small filling defect in mid portion of CBD. A sphincterotomy was performed. Common bile duct was balloon swept but no stones were found. While her liver functions improved, she was operated after six weeks.

At operation, dense adhesions were found between gall bladder, CBD, omentum, colon and stomach. Gall bladder was thick walled, fibrotic and shrunken containing calculi and adherent with colon and pylorus. On further exploration, a fistulous communication of gallbladder with pylorus was found. There was also Marrizi’s syndrome type II with dilated CBD. Common bile duct was explored but no calculi were found and it was flushed with normal saline with no distal or proximal obstruction. T-tube of 18 Fr was placed in CBD. A T-tube cholangiogram was performed on 15th post-op day, which shows normal flow of dye into duodenum and no abnormality. Histopathology of the tissue from fistula margins revealed chronic non-specific inflammation.
DISCUSSION

A biliary fistula is an established and abnormal connection between any portion of the biliary tree and some other area. Ninety percent of the internal biliary fistulas are cause by gall stone disease and five percent are secondary to peptic ulcer.¹ The symptoms of the non-malignant internal fistulas are similar to those of the chronic cholecystitis and dyspepsia. Types of internal fistulas are Bilio-enteric (e.g, cholecysto-duodenal, cholecysto-colic, cholecysto-gastric, choledocho-duodenal), Bilio-bilial (Mirizzi’s syndrome), Broncho/pleuro-bilial and Cholecysto-renal.

Cholecysto-duodenal fistulas are common whereas cholecysto-gastric fistulas are rare.² Among the internal fistulas, cholecysto-gastric fistulas are not very common. They are due to gallstones, gastric ulceration or due to the malignant infiltration of carcinoma of gall bladder or stomach. Cholangitis is likely to be associated with any type of biliary fistula.³ Commonest complications of the fistulas are infections of peritoneal cavity, cholangitis or gall stone ileus. Hyponatremia, inanition and weight loss is not common in internal fistulas as compared to external. Radiology of abdomen shows a gas or barium in the biliary tree.²,⁴

Majority of the patients are diagnosed per-operatively. Preoperative diagnosis is not easy and should be suspected after careful evaluation and exclusion. If possible, every attempt should be made to establish the anatomy and cause of fistula preoperatively.⁵ Contrast studies, ERCP, transhepatic cholangiography, MIBG scan, HIDA scan and cytological evaluation of aspirate may be helpful in diagnosis.⁶ The value of surgical exploration for the determination of the cause should not be overemphasized. In surgical practice, initial investigations localize the fistula and surgical treatment establishes the cause of fistula. Historically, fistulas caused by peptic ulceration should be suspected when ulcer symptoms disappear after formation of fistula due to alkalinity of the bile from the gall bladder.¹ Control of infection and correction of electrolyte
imbalance is also important before commencing to surgery. In case of distal obstruction of CBD, preoperative drainage should be established, if possible.\textsuperscript{4,5} Surgical separation and reconstruction of the structures should be carried out. It may be difficult or impossible especially in case of neoplastic infiltration. In such circumstances, an alternate drainage or any other suitable procedure should be considered, depending upon the situation.

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