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Images in...

Spontaneous cholecystocutaneous fistula

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DESCRIPTION

A 76-year-old man presented with right upper quadrant (RUQ) swelling (figure 1A). He required endoscopic retrograde cholangiopancreatography with sphincterotomy 6 months earlier but declined cholecystectomy. CT demonstrated a large gallstone protruding through the abdominal wall (figure 2B). He underwent open cholecystectomy. Histology showed chronic cholecystitis and a fistulous tract.

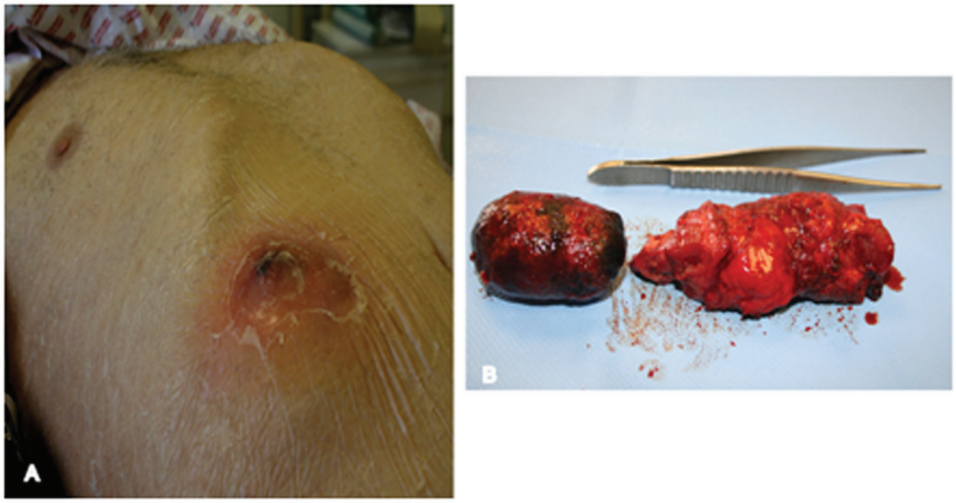

Figure 1 (A) Abdominal wall abscess in right upper quadrant. (B) Gallstone and gallbladder with fistulous tract.

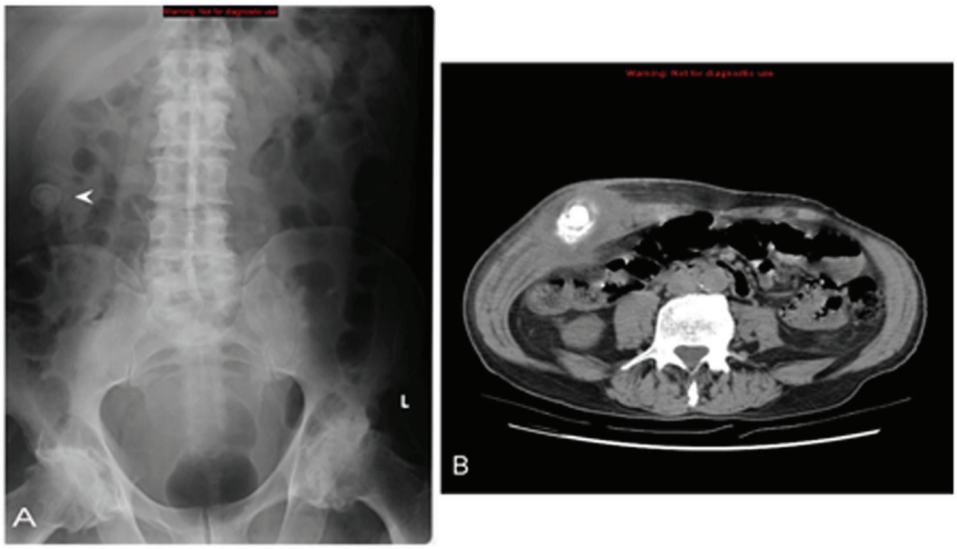

Figure 2 (A) Abdominal x-ray demonstrating calcified gallstone (arrowhead). (B) CT demonstrating a large gallstone within a grossly inflammed gallbladder extruding through anterior abdominal wall, marked overlying tissue inflammation and fistulous tract.

Cholecystocutaneous fistula, an abnormal communication between gallbladder and skin was first described by Thilesus in 1670. Spontaneous fistulae are usually a complication of neglected gallstones causing perforation, which either drains freely into the peritoneal cavity or becomes adherent to adjacent structures or rarely becomes adherent to the abdominal wall. Majority of cases are associated with cholelithiasis, although isolated reports have described carcinoma of the gallbladder and acalculous cholecystitis. Declining incidence probably reflects prompt diagnosis and management of acute cholecystitis with antibiotics and surgery, with less than 20 cases reported in the past 50 years.[1] The external opening is commonly in the RUQ, although fistulation in the left upper quadrant, periumbilical, lumbar and gluteal region are described.[2] The discharge in the presence of obstruction may be purulent with an empyema or mucoid with a mucocele, while in the absence of obstruction is bilious. Typical presentation and previous history of cholecystitis should suggest diagnosis while both ultrasound and CT help confirm this. Cholecystectomy and fistulotomy performed open or laparoscopically is the treatment of choice. Spontaneous closure may occur after cholecystostomy; however, this carries the possibility of further stone formation and should only be considered in high-risk patients.[3]

Competing interests None.

Patient consent Obtained.

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