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GIANT GALLBLADDER CALCULI WITH BILIARY PANCREATITIS - A RARE CASE REPORT

General Surgery

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ABSTRACT

Background: Cholelithiasis is the most common cause of acute pancreatitis, accounting 35%-60% of cases and the main question is over the correct timing of every intervention. Patients who are recovering from an acute episode of biliary pancreatitis can be offered alternative options in their management, which include cholecystectomy, endoscopic retrograde cholangiopancreatography (ERCP) and sphincterotomy, or conservative management with no definitive treatment. ERCP and sphincterotomy on index admission can prevent recurrent episodes of pancreatitis until cholecystectomy is performed.
Case report: 40 year old lady presented with complaints of upper abdominal pain for 1 week associated with nausea and vomiting . Abdomen examination showed tenderness in right hypochondrium and epigastrium. USG abdomen showed a distended gall bladder with huge calculi and grossly dilated CBD .ERCP showed choledocholithiasis .ERCP with stenting was done initially in her first admission following which laparoscopic cholecystectomy was done which showed huge gallbladder calculi measuring 7.5cm x 3cm .
Conclusion: Large gallstones may pose technical difficulties when performing a laparoscopic cholecystectomy. Patients with large gallstones have a higher risk of conversion to open. This particular case shows a rare presentation of biliary pancreatitis with huge gall stone treated by laparoscopic cholecystectomy

KEYWORDS

INTRODUCTION

The most common cause of acute pancreatitis in many western and Asian countries is cholelithiasis, accounting for 35%-60% of cases[1]. The gall bladder may contain a single large stone or multiple smaller ones. The pathophysiology of gallstone formation is a combination of defect in lipid metabolism and super-saturation of bile contents, especially cholesterol. About 10% of population have gall stones, but majority experience no symptoms and needs no treatment. The following alternatives are feasible for the treatment of patients fit for surgery: index cholecystectomy, interval cholecystectomy, ERCP and endoscopic sphincterotomy followed by delayed cholecystectomy. We encountered a rare case of giant gallbladder calculi managed successfully by laparoscopic cholecystectomy .

CASE REPORT

40 year old lady, known diabetic on oral hypoglycemic agents presented with complaints of upper abdominal pain for 1 week . Pain was not associated with food intake and no history of radiation to back. She gave history of nausea and vomiting 2 episodes. No history of fever . No previous history of jaundice /malena /bleeding per rectum . No h/o substance abuse or previous surgical history.

On examination, she was icteric, afebrile and adequately hydrated . Her vitals were normal and her abdomen was not distended soft , and tenderness present in right hypochondrium and epigastrium and no mass was palpable , no palpable organomegaly .Her routine blood investigations revealed elevated total counts of 11,000/mm^3 and her liver function tests showed increased total bilirubin of 6.0mg/dl. Amylase and lipase was also elevated. USG(ultrasound) abdomen revealed over distended gallbladder with a calculi of size 6.3 x 1.6cm and grossly dilated common bile duct with central and peripheral (intra hepatic bilary radical dilatation) IHBRD.

She was subjected to Magnetic Resonance Cholangio Pancreaticography (MRCP) which showed cholelithiasis with diffuse gallbladder(GB) thickening , dilated cystic duct , choledocholithiasis at distal common bile duct (CBD) with proximal obstructive biliopathy , prominent pancreas with edematous head and uncinated process with surrounding peripancreatic fluid and dilated main pancreatic duct (MPD)-suggestive of acute pancreatitis .

She underwent ERCP and wide sphincterotomy with CBD stenting . Her icterus improved and she was optimised for elective Laparoscopic Cholecystectomy. She underwent the same and intraoperatively distended GB was observed with normal Calots triangle. GB was brought out through the umblical port site . The size of the GB calculi was 7.5 x 3 cm and sent for histopathological examination .Her post operative period was uneventful and she was discharged on POD 3.

DISCUSSION

Gallstone disease is common. Ultrasound can accurately find the size of a gallstone and it should be done routinely. Complications from gallstones are the second most common reason for hospital admission, and are associated with a high mortality[3]. Operative intervention during an attack of biliary pancreatitis is an effective way to treat the biliary tract disease and prevent the development of further attacks. Laparoscopic cholecystectomy has now emerged as the procedure of choice to treat cholelithiasis. Large gallstones may pose technical difficulties when performing a laparoscopic cholecystectomy. Patients with large gallstones may be more suited to admission as an inpatient as they have a higher risk of conversion to open[6]. Giant Gall bladder stone can be defined as stones larger than 5 cm in its widest diameter or weighing above 70 gm[4]. Laparoscopic cholecystectomy is the gold standard treatment for gall stone disease but very large gall stone may require open cholecystectomy[5].Open cholecystectomy was considered as the surgery of choice for giant gallstones though there are a only few studies which reported such gallstones removed laparoscopically. And our case shows successful removal of such giant gallstone .

CONCLUSION

Giant gallstone of size more than 5 cm is rare, although open cholecystectomy is indicated, it is not the only treatment of choice. This is a unique case which emphasises the efficacy of laparoscopic cholecystectomy in removal of giant gallstones.

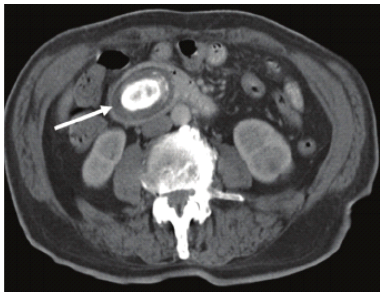

Figure 1:CECT abdomen

Figure 2: Post op specimen – Gallstone

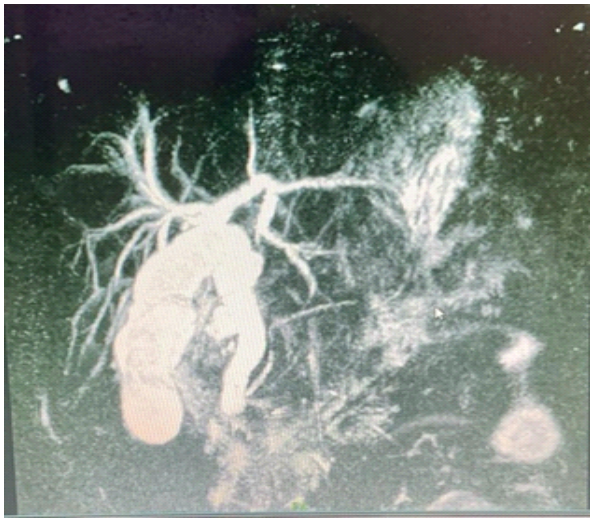

Figure 3:MRCP

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