ISSN: 0975-8585

Research Journal of Pharmaceutical, Biological and Chemical Sciences

Case Report: Rare Presentation Of Cholecystocolonic Fistula.

Manoj Kumar[1], Venkatesh RS[2]*, Roop Dhanjal[3], and Panchami[4].

[1]Assistant Professor, Department of General Surgery, Vydehi Institute of Medical Sciences and Research Centre, Karnataka, India.
[2]Post Graduate, Department of General Surgery, Vydehi Institute of Medical Sciences and Research Centre, Karnataka, India.
[3]Post Graduate, Department of General Surgery, Vydehi Institute of Medical Sciences and Research Centre, Karnataka, India.
[4]Assistant Professor, Department of General Surgery, Vydehi Institute of Medical Sciences and Research Centre, Karnataka, India.

ABSTRACT

Cholecystocolonic Fistula (CCF) is a rare and late complication of Gallstone disease with incidence of 1 in every 1000 cholecystectomies. CCF can typically present as diffuse pain abdomen or Gallstone ileus with previous history of Gall stone disease. It represents the second most common fistula, most common type being between gall bladder and duodenum. This can be attributed to chronic inflammation as a result of gall stones. Cholecystocolonic fistula is a rare complication of chronic cholecystitis with gallstones, often presenting with abdominal pain, nausea, or vomiting. Surgical management is tailored based on the patient's condition, extent of inflammation, and intraoperative findings. In our case, a simple cholecystectomy and fistula excision with primary colonic defect closure was performed due to minimal inflammation. However, complex cases may require more extensive procedures, such as hemicolectomy or staged approaches. The decision for surgical intervention is influenced by patient comorbidities and intraoperative assessment, and thus there is no definitive procedure of choice applicable to all cases.

Keywords: cholecystocolonic fistula, Gallstone disease, gall bladder

https://doi.org/10.33887/rjpbcs/2024.15.5.55

Corresponding author

ISSN: 0975-8585

INTRODUCTION

Cholecystocolonic Fistula (CCF) is a rare and late complication of Gallstone disease withincidence of 1 in every 1000 cholecystectomies [1]. CCF can typically present as diffuse pain abdomen or Gallstone ileus with previous history of Gall stone disease. It represents the second most common fistula, most common type being between gall bladder and duodenum. This can be attributed to chronic inflammation as a result of gall stones. Few other mechanismsmentioned in literature include Gall bladder Malignancy, Previous Gastric Surgery, Previous Cholecystectomy. Management of this rare complication depends on time of presentation andseverity of disease.

Case Report

A 63-year-old male presented to Emergency department with diffuse abdominal pain for 3 days associated with vomiting and anorexia with Type 2 Diabetes mellitus and a known Hypertensive. On examination, Patient was Hemodynamically stable, with right upper abdominal tenderness.

On CECT Abdomen: Liver - Enlarged in size and shows an ill-defined predominantly hypodense lesion, showing peripheral wall enhancement and no central enhancement on porto- venous phase, measuring ~ 6.3 x 6.5 x 13 cm (AP x TR x CC) involving segments VII and VI.There is minimal perilesional edema. The mid third portion of the lesion is heterogeneous. Thesuperior portion of the lesion is extending the capsular surface of the liver under the diaphragm.However, no evidence of any subcapsular collection. Right hepatic vein is in close relation to the lesion, however normal contrast opacification noted. No evidence of intra hepatic biliary dilatation seen. Portal vein and its branches appear normal. Hepatic veins and IVC appear normal.

Gallbladder Contracted and shows air foci within the lumen. minimally dense focus measuring 8 mm noted in the lumen on plain CT study. Air foci noted within the intrahepatic biliary tree, common hepatic and common bile duct pneumobilia.

Gastrointestinal Tract: There is probable fistulous communication between the proximal transverse colon and the contracted gall bladder. No significant adjacent fat stranding, Likely Cholecystocolonic fistula.

On Colonoscopy: Visualised Mucosa is normal, there is 1 cm fistulous opening seen in thehepatic flexure. The margins of the opening are clean. There is mild surrounding edema and erythema. There is no tumor/stricture/growth seen, S/O Cholecystocolonic fistula.

The Patient underwent Laproscopic Cholecystectomy with Excision of the Fistulous Tract and primary repair of the Colonic defect. It was noted intra-Operatively- A fistulous connectionbetween Hepatic flexure of the colon and Gall Bladder. The Excised specimen was sent for HPE. Post Operative period was Uneventful.

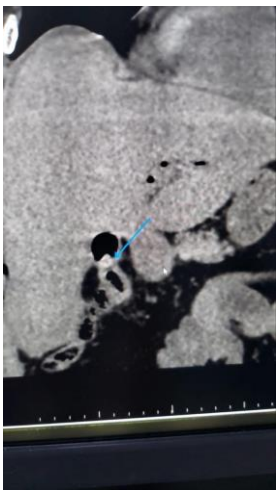


Figure 1: CECT Abdomen

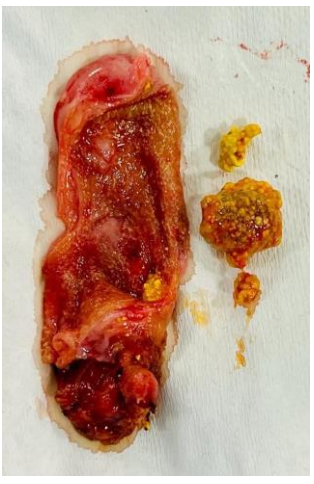
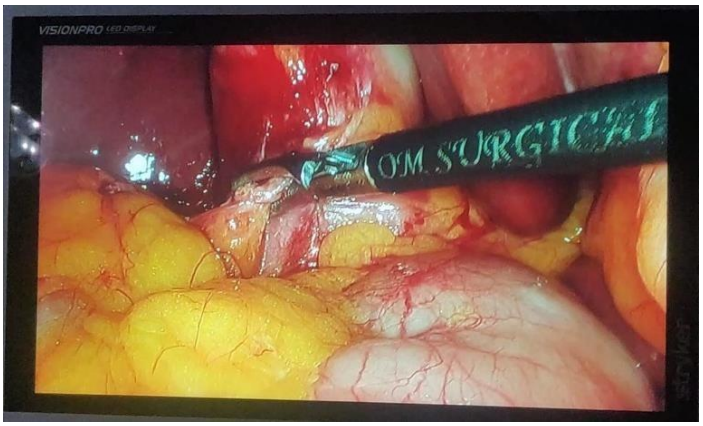


Figure 2: Gross Specimen

ISSN: 0975-8585

Figure 3: Intra-Operative



DISCUSSION

Cholecystocolonic fistula, an uncommon or rare complication of Chronic Cholecystitis with Gall stones and most commonly present with Abdominal pain with Nausea or Vomiting with or without derangement in liver function tests depending on presentation. In our case the patientpresented with acute pain abdomen with no signs of Peritonitis and it was noted intraoperatively minimal fat standing and inflammation, as a result of which a simple cholecystectomy with excision of the fistulous tract was performed with primary closure of the colonic defect. Surgical Management varies depending on the extent of inflammation and severity, in case of dense adhesions and inflammation, there might be a need of hemicolectomy based of the segment of colon involved. The most frequently performed procedure is an enterolithotomy, which appears to be performed in critically ill, high-risk patients, followed by cholecystectomy later, or a single stage procedure (enterolithotomy, cholecystectomy and fistula closure. The procedure of choice in such instances is debatable as per few literature, procedure of choice varies case – to – case and its decision is multifactorial based on patient co-morbidities, intra-operative findings [2-5].

CONCLUSION

Cholecystocolonic fistula is a rare complication of chronic cholecystitis with gallstones, often presenting with abdominal pain, nausea, or vomiting. Surgical management is tailored based on the patient's condition, extent of inflammation, and intraoperative findings. In our case, a simple cholecystectomy and fistula excision with primary colonic defect closure was performed due to minimal inflammation. However, complex cases may require more extensive procedures, such as hemicolectomy or staged approaches. The decision for surgical intervention is influenced by patient comorbidities and intraoperative assessment, and thus there is no definitive procedure of choice applicable to all cases.

REFERENCES

[1] Ruben D. Salas et al., Case Report: Cholecystocolonic fistula: two different presentations of this rare complication of gall stone. Journal Of Surgical Case Reports 2022; 11:1-4.
[2] Reddy AK, Dennett ER. Cholecystocolonic fistula: a rare intraluminal cause of large bowel obstruction. BMJ Case Rep 2016. doi:10.1136/bcr-2016-217141.
[3] Renato Costi, Bruto Randone, Vincenzo Violi, et al., Cholecystocolonic fistula: facts and myths. A review of the 231 published cases. J Hepatobiliary Pancreat Surg 2009;16:8–18.
[4] Okidi R, Ogwang MD, Natumanya R, Mukalazi A, Kyomuhendo T, Okello TR. Incidental cholecystocolonic fistula in obstructive jaundice. Clin Case Rep 2021;9: e04510.
[5] Kumar D, Goyal D, Singh P, Bhukal R, Singla A. Management of cholecystocolonic fistula: a rare case report. Int Surg J 2022;9(9):1662-1664.