The patient presented at 65 years of age. Talal finding. However, liver anomalies associated with hypertension. In our patient the right lobe was connected to the gall bladder occurring without any connection to the normal diaphragm have been reported in literature. The accessory lobes may run the risk of torsion of the left lobe of the liver can lead to gastric volvulus. Conversely, defective development of the right lobe either remains clinically latent or leads to portal hypertension.

Anomalies related to excessive development of the liver lead to formation of accessory lobes annexed to the liver. The accessory lobes may run the risk of torsion. Cases with thoracic accessory liver lobe with a normal diaphragm have been reported in literature. Ectopic liver has been described in the wall of the gall bladder occurring without any connection to the liver. In our patient the right lobe was connected to the left lobe by a thin bridge of liver tissue.

References

Correspondence to: Dr G B Daver, 2/11 Professors Quarters, J J Hospital Campus, Byculla, Mumbai 400 008. E-mail: gdbakhshi@yahoo.com
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Pleuro-biliary fistula — a delayed complication following open cholecystectomy

Ramakrishna Prabhu, Charudatta Bavare, Harshad Purandare, Avinash Supe

Department of Surgical Gastroenterology, Seth G S Medical College and K E M Hospital, Mumbai 400 012

A 24-year-old lady presented with bilious expectoration and history suggestive of obstructive jaundice, 16 months following open cholecystectomy. Pleurocentesis was done, followed by intercostal drainage, which drained about 300 mL bilious fluid per day for a month. Her symptoms of obstructive jaundice were relieved.

A pleuro-biliary fistula was demonstrated by percutaneous transhepatic cholangiogram, HIDA scan and ERCP, which showed complete cut-off at the lower end. The patient underwent bilio-enteric bypass with gastric access loop, with complete healing of the pleuro-biliary fistula. [Indian J Gastroenterol 2005;24:28-29]

Several causes of biliary-bronchial fistula have been described, including trauma, parasitic liver disease, suppurrative complications of biliary obstruction, and congenital anomalies.

A 24-year-old lady was admitted elsewhere with colicky, non-radiating pain in the right hypochondriac region, increasing after meals, for 7 months. She underwent open cholecystectomy, but operative details were not available. Postoperatively, on day 2, she developed acute-onset severe pain in the right hypochondrium, with ultrasonography showing minimal fluid collection in the gall bladder fossa. Ultrasonography-guided aspiration of the fluid showed it to be bilious. She was treated conservatively and was asymptomatic since then.

Sixteen months later, she presented with acute-onset breathlessness, copious bilious expectoration, and jaundice. X-ray chest showed a large right-side pleural effusion. Pleurocentesis revealed 300 mL of frank bilious fluid. The next day, an intercostal drain was placed on the right side, draining 300 mL bilious fluid per day for a month. Her jaundice gradually decreased. The patient was then referred to a tertiary-care institute.

ERCP showed complete cut-off of the proximal common bile duct. Percutaneous transhepatic cholangiogram showed a...
tightly stricture at the confluence of the hepatic ducts. A drain was placed in the same sitting; it drained about 200 mL per day, with the intercostal drain output decreasing to 20-30 mL per day. This new drain came out accidentally on the 7th day, with an increase in the intercostal drain output to the earlier levels of around 300 mL per day. The patient was then referred to our institute.

The patient was non-icteric. HIDA scan showed no flow of dye into the gastrointestinal tract; instead, it was flowing into the intercostal drain (Fig). CT scan showed the intercostal drain lying near the posterio-superior quadrant of the liver, with minimal necrosis of adjacent liver. There was no evidence of intra-abdominal collection.

On exploration of the abdomen it was not possible to access the right hepatic duct due to the right branch of the portal vein traversing it anteriorly. On opening the left duct, a posterior communication was seen between the two ducts. The distal portion of the common hepatic duct was fibrosed. A side-to-side left hepatico-jejunostomy was done, with a gastric access loop (gastrojejunostomy) and a trans-anastomotic drain brought out trans-jejunally, on the right side. An abdominal drain was kept in the Morrison’s pouch.

Postoperatively, her recovery was uneventful, with the intercostal drain output drying up. There was a gradual decrease in the trans-anastomotic drain output. This drain was removed on the 6th day. HIDA scan on the 8th day (Fig) showed good uptake by both lobes of the liver and good flow of bile into the gastrointestinal tract. There was no leak evident into either the intercostal drain or the peritoneal cavity.

The intercostal drain was removed on the 12th day and the patient was discharged. The trans-anastomotic drain was removed after 6 weeks. She is leading a normal life at 30 months.

Trauma is the most common cause of thoracobilia in Western society. Initial nonoperative treatment or overlooked injuries to the hepatobiliary and pulmonary systems are the most frequent factors in the development of thoracobilia.

Suppurative complications of benign and malignant biliary obstruction are other causes. In the presence of unrelieved biliary obstruction, rupture of an intrahepatic abscess or presence of postoperative biliary extravasation can lead to subphrenic biliary abscess. This may rupture trans-diaphragmatically, with establishment of a biliary-pleural or biliary-bronchial fistula. Biliary fistulas secondary to benign or malignant biliary strictures or secondary to abdominal abscesses related to perforated cholecystitis or the complications of choledocholithiasis have reportedly led to thoracobilia.

Development of broncho-biliary fistula following open cholecystectomy is an unusual complication. Accidental trauma to the common bile duct and subsequent formation of a cholangitic abscess in the right lobe, with trans-diaphragmatic rupture later, might have been the sequence of events.

Warren and colleagues reviewed their results in 15 patients with thoracobilia. All but one were controlled with a primary abdominal approach. One patient later required pulmonary lobectomy for persistent pulmonary suppuration. Similar results were obtained by Boyd.

References

Correspondence to: Professor Supe. E-mail: avlaupa@vani.com
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Hepatic resection for metastasis from adenoid cystic carcinoma of parotid gland

Sajid S Qureshi, Mandar S Nadkarni, Shailesh V Shrikhande, Sangeeta Desai, Kedar Deodhar,* Mukt Ramadwar,* Parul J Shukla
Departments of Surgical Gastroenterology and *Pathology, Tata Memorial Hospital, Mumbai 400 012

Adenoid cystic carcinoma is the commonest malignant tumor of the submandibular and minor salivary glands; the parotid gland constitutes a small share of this neoplasm. We present a 30-year-old woman with solitary liver metastasis from an adenoid cystic carcinoma of the parotid gland, which had been surgically treated 10 years ago. The patient underwent suc-