CASE SNIPPETS

Unusual Gall Bladder Perforation - Definition of a New Type

MD IBRARULLAH, R SAXENA, S S SIKORA, V K KAPOOR, S P KAUSHIK

Department of Surgical Gastroenterology,
Sanjay Gandhi Postgraduate Institute of Medical Sciences, P B 375, Raebareli Road, Lucknow 226 001

Abstract
A patient with unusual compound perforation of gall bladder is presented; on this basis, it is proposed to add a new type to the existing Niemcze’s classification for gall bladder perforation. (Indian J Gastroenterol 1992; 11: 170).

Key words: Cholecystobiliary fistula

Gall bladder (GB) perforations are uncommon. Depending on the mode of presentation, these have been classified into three types.1,2 We describe here a patient with compound GB perforation (Niemcze’s type I or type III) and on this basis propose a new type of GB perforation.

A 34 year old woman presented with constant non-radiating right upper quadrant pain, low grade pyrexia and progressive abdominal distention of 8 days’ duration. Examination revealed tachycardia with signs of localized peritonitis in the right upper quadrant. Ultrasonography revealed gall stones, pericholecystic fluid collection and free fluid in the peritoneal cavity. The fluid was bile-stained on aspiration. Emergency laparotomy revealed free bile in the peritoneal cavity and a contracted sessile GB containing multiple stones. The GB had a perforation at the neck close to the common hepatic duct. A stone impacted at the GB neck was eroding into the common bile duct creating a cholecystobiliary fistula. Partial cholecystectomy and repair of the common hepatic duct with a GB flap (choledochojunostomy) and T-tube cholecdochotomy and peritoneal culdotomy were performed after which the patient made an uneventful recovery.

Modified Niemcze’s classification divides GB perforations into (i) type I - acute free perforation, (ii) type II - walled off perforation with formation of pericholecystic or right upper quadrant abscess, and (iii) type III - chronic perforation with internal or external fistula formation.1,3 Internal fistulae in type III perforations may be bilioenteric or biliobiliary.3 In this setting of internal biliary fistulation, a stone eroding into the common bile duct may at a later date cause perforation of the neck of the GB into the free peritoneal cavity (resulting in a type I perforation) because of recurrent inflammation and pressure necrosis. This was indeed the case in the present case. In our opinion, such a compound GB perforation (Fig), hitherto unnamed, needs to be classified as a separate type, i.e type IV perforation. A high index of suspicion and careful dissection alone can uncover such a compound perforation; meticulous and complex reconstructive surgery gives rewarding results whereas a careless cholecystectomy in such a situation may be the harbinger of a post-cholecystectomy biliary stricture.

References