Fig: Adenocarcinoma of stomach with signet ring cells (single arrowhead) and epithelioid granulomas showing Langherhan’s cell (double arrowhead) (H&E, 40X)

Case Snippets

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Asymptomatic T-tube remnant in common bile duct

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A 46-year-old lady presented with itching, five years after a primary common bile duct repair following cholecystectomy. Prior to this she underwent an interno-external biliary drainage. At laparotomy the horizontal limb of a T-tube was found in the common hepatic duct. Eleven months after a Roux loop hepatico-jejunostomy she is asymptomatic. [Indian J Gastroenterol 1999;18:180-181]

Key words: Biliary system, retained T-tube

Most surgeons drain the common bile duct (CBD) with a T-tube after exploring it for stones. Bile leakage, peritonitis, bacteraemia, bile duct strictures are some of the complications seen after removal of the T-tube. We report an unusual complication of T-tube fragmentation in the choledochus. This was removed four years after open cholecystectomy was done for silent gallstones, complicated by CBD injury.

A 46-year-old lady underwent abdominal hysterectomy and open cholecystectomy for incidental gallstones detected by ultrasonography during the course of investigation for dysfunctional uterine bleeding. Two days following surgery she developed icterus. At second exploration, she was found to have had a CBD injury for which a choledocho-duodenostomy was done over a T-tube. The T-tube was removed on the sixth postoperative day.

The patient was asymptomatic for four years after this, when she developed itching and icterus. She was treated by a dermatologist for six months. With no improvement in symptoms she was referred to a gastroenterologist. Endoscopic retrograde cholangiogram showed a mid-CBD stricture. She underwent percutaneous transhepatic cholangiogram (PTC) and biliary drainage (PTBD) with an interno-external stent. With this she improved and was

References


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The breaking of a T-tube during its removal is a rare event. The main point of resistance when a T-tube is pulled is at the junction of the horizontal and vertical limbs, and breaks may occur at this point. Guttering the tube and cutting a V notch at the junction are recommendations for easy removal of the T-tube; however, these may weaken the T-tube. Endoscopic removal of retained T-tube has been reported. Use of a Gruntzig balloon dilatation catheter to remove a retained T-tube has also been reported.

PVC tubes harden with time and are associated with a higher incidence of bile peritonitis. Latex or silicone T-tubes have less complications. It is important to carefully examine the T-tube after its removal to ascertain that no portion has been left behind. Interestingly, our patient was totally asymptomatic for four years after surgery and at no time had cholangitis, perhaps because of adequate drainage. Along with hemobilia, a retained T-tube remnant should be remembered as a cause of filling defects in the CBD in a patient who has undergone CBD exploration.

References

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