

An Unexpected Complication of Cholecystitis

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1. Clinical Image

A 54-year-old woman with history of cholangiocarcinoma with treatment consisting in endoscopic biliary stents implantation and six month of chemotherapy, was referred to the emergency department for fever and shivers started 7 days earlier. On physical examination, she presented a significant pain in the abdominal right upper quadrant, tachycardia, and hypotension. Blood tests revealed a C Reactive Protein level of 270 mg/l and a lactate level of 5 mmol/l. Contrast enhanced computed tomography scan of the abdomen showed an acute cholecystitis with a wall thickening of the gall bladder and a pericholecystic fat infiltration (Figures 1a, 1b red arrow). The Gall bladder appeared to be perforated into the liver leading to the formation of an abscess with a hypodense center and a peripheral enhancement (Figures 1a, 1b white arrow). The patient developed a septic shock and was transferred in our intensive care unit. She required invasive mechanical ventilation, norepinephrine administration and an empirical systemic antibiotherapy was introduced. Surgical explo-

ration by laparotomy was performed because of peritonitis signs. There was pus in the peritoneal cavity coming from a perforated liver abscess. A peritoneal lavage was realized and an external tube drainage was inserted into the abscess. Cultures from the abscess revealed the same bacteria than in the blood: *Escherichia coli* and *Proteus mirabilis*. A cholecysto-hepatic communication was confirmed by cholangiography using the hepatic tube, showing an opacification of the liver abscess first (Figure 1c, white arrow) and then an opacification of the gall bladder (Figure 1c, red arrow). The patient improved clinically and was discharged at day 20 in surgical ward.

The formation of a liver abscess due to intrahepatic perforation of the gall bladder is a rare complication of cholecystitis. In such condition, a conservative treatment is usually performed with percutaneous drainage of the abscess and subsequent cholecystectomy [1]. Computed tomography scan and ultrasonography are the most important tools to lead to the diagnosis and to manage the drainage procedure [2].

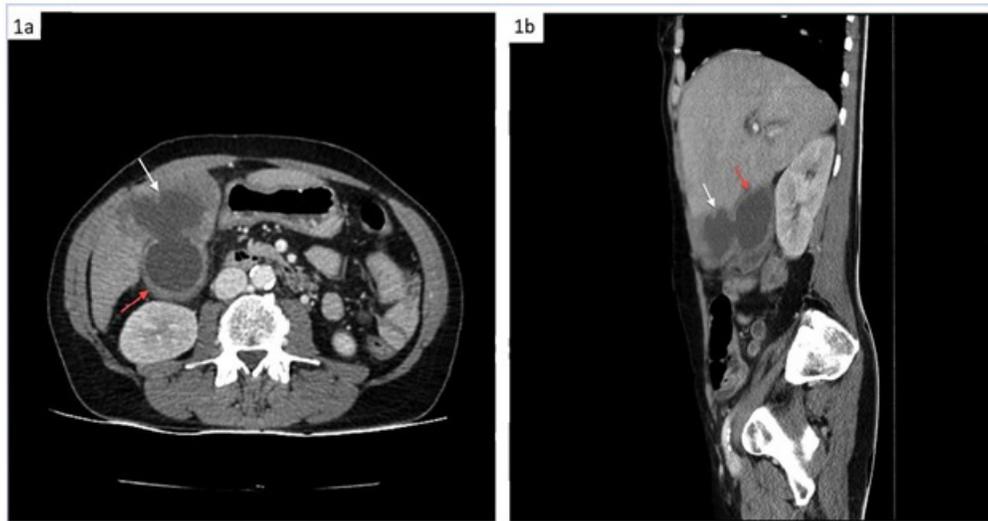


Figure 1a, 1b: Abdominal CT scan (fig 1a horizontal section; Fig 1b sagittal section) showing a cholecystitis (red arrow) and a liver abscess (white arrow)



Figure 1c: Cholangiography attesting to the presence of a communication between the liver abscess (white arrow) and the gall bladder (red arrow)

References

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