Case Report

A rare case of cholecystocutaneous fistula
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INTRODUCTION

Cholecystocutaneous fistula is a rare complication of cholecystitis. Courvoisier reported 169 cases in the 19th century.[1] However, since 1900 just 65 cases have been reported.[2] According to a 2005 study, a total of 226 cases have been reported.[3] Incidence in current times has been reduced due to more rapid diagnosis and timely surgery. Although fistulas are rarely associated with acalculous cholecystitis and carcinoma of the gallbladder.[2-4] Cystic duct obstruction leads to an increase in gallbladder pressure and reduced perfusion with necrosis, which lead to gallbladder perforation. The most common location is the right upper quadrant that is for the exit tract of the fistula, but few locations such as the right groin, umbilicus, and gluteal region have also been documented.[3]

CASE REPORT

A 35-year-old female presented in the outpatient department of general surgery with chief complaints of discharge from the supraumbilical region for the past 2 years as shown in Figure 1.

Spontaneous cholecystocutaneous fistula is an extremely rare complication of acute Cholecystitis. A total of 169 cases have been reported in the past 50 years. We are also reporting this very rare complication. A 35-years-old female patient presented to us in the surgery outpatient department with complaints of a supra umbilical discharging sinus for the past 2 years. High-dose contrast-enhanced computed tomography of whole abdomen was done and patient revealed cholelithiasis with choledocholithiasis with a cholecystocutaneous fistula. An endoscopic retrograde cholangiopancreatography removal of the common bile duct stone with stenting was followed by an exploratory laparotomy and cholecystectomy with fistulectomy. The patient was discharge in a satisfactory condition.

KEY WORDS: Gall stone disease, cutaneous fistula, choledocholithiasis
Laparotomy was done 2 days later. A fistula track was identified and excised along with stone removal and a cholecystectomy was performed. As shown in Figure 4.

Post-operative period was uneventful and patient was discharged on post-operative day 12 with advice for removal of stent after 1 month. Chronic cholecystitis with cholelithiasis of gallbladder revealed on histological examination.

**DISCUSSION**

Biliary fistulas are two types internal and external. Internal fistulas are more common, 75% of them connecting to the duodenum and 15% to the colon. The remaining 10% are internal fistulas that communicate with the stomach or jejunum, or have multiple communications such as cholecysto-duodeno-colic fistula. External biliary fistulas are rare but they usually complicate gallstone disease and can occur secondary to biliary injury during a surgical procedure. The external opening of a cholecystocutaneous fistula is found generally in the right hypochondrium. It can also involve the left hypochondrium (45%), umbilicus as in our case (27%), right lumbar region, right iliac fossa, and gluteal region.

**CONCLUSION**

In our case with the help of contrast-enhanced computed tomography whole abdomen diagnosis of cholecystocutaneous fistula with common bile duct calculi was made, common bile duct calculi were managed with endoscopic retrograde cholangiopancreatography and cholecystocutaneous fistula with cholelithiasis was managed with an exploratory laparotomy cholecystectomy and fistulectomy.

**REFERENCES**