Case Report

A rare case of cholecystocutaneous fistula

Ashish Yadav, Chandra Prakash Pandey, Sharad Seth

Department of General Surgery, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

Corresponding Author:
Ashish Yadav,
Department of General Surgery,
Rohilkhand Medical College and Hospital, Bareilly,
Uttar Pradesh, India.
E-mail: ashishyadav10027@gmail.com

Received: 07-04-2020
Accepted: 22-04-2020
Published: 02-05-2020

How to cite this article:
Yadav A, Pandey CP, Seth S. A rare case of cholecystocutaneous fistula. Int J Adv Integ Med Sci 2020;5(2):62-63.

Source of Support: Nil,
Conflicts of Interest: None declared.

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 complains 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

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]

Access this article online	
Website: www.ijaims.net	Quick Response code

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.

She reported occasional nausea and vomiting on presentation her vitals were normal and she is afebrile. Mild icterus was noted. Her abdomen was soft, non-distended non tender no guarding and rigidity bowel sound is present with discharging sinus present over supra umbilical region computed tomography (CT) which showed a contracted gall bladder with common bile duct stone in association with this CT fistulogram showed a cholecystocutaneous fistula with collection along the tract and a stone in the tract. As shown in Figure 2.

Patient was initially managed by endoscopic retrograde cholangiopancreatography with common bile duct stone removal and stenting. As shown in Figure 3.

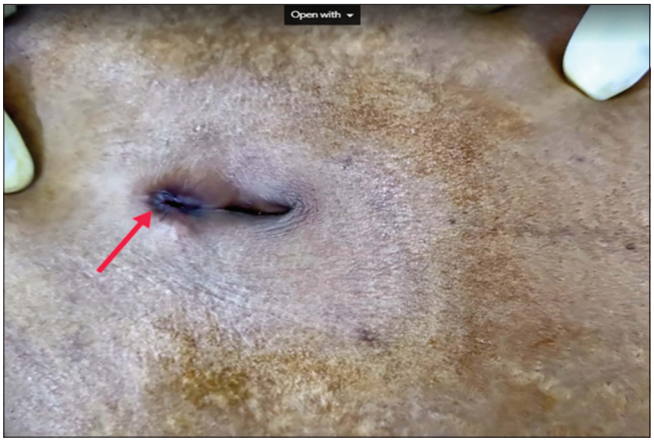


Figure 1: Shows cutaneous fistula tract

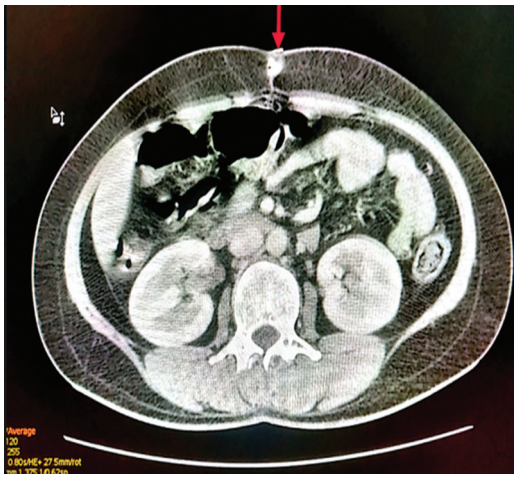


Figure 2: CT scan shows fistula tract arising from gall bladder

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 discharge 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.[5] External biliary fistulas are rare but they usually complicate gallstone disease and can occur secondary to biliary injury during a surgical procedure.[6] 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.[4]

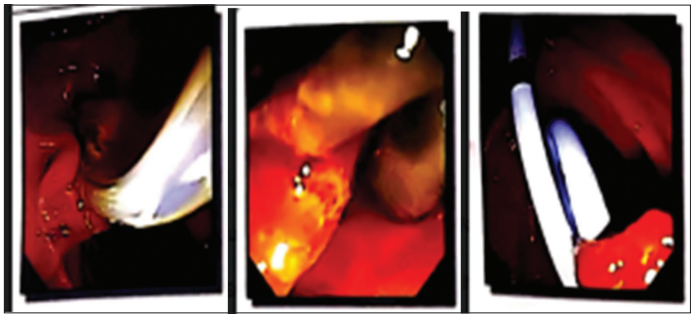


Figure 3: ERCP with stenting

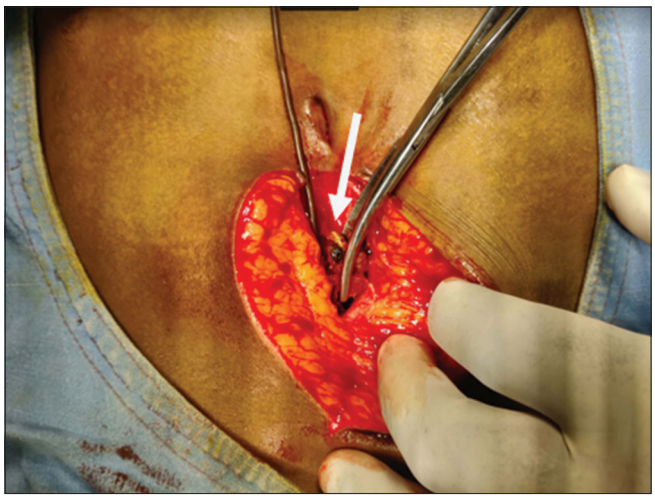


Figure 4: Intra operative picture of fistula tract

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

1. Gibson TC, Howat JM. Cholecystocutaneous fistula. Br J Clin Pract 1987;41:980-2.
2. Birch BR, Cox SJ. Spontaneous external biliary fistula uncomplicated by gallstones. Postgrad Med J 1991;67:391-2.
3. Yüceyar S, Ertürk S, Karabiçak I, Onur E, Aydoğan F. Spontaneous cholecystocutaneous fistula presenting with an abscess containing multiple gallstones: A case report. Mt Sinai J Med 2005;72:402-4.
4. Vasanth A, Siddiqui A, O'Donnell K. Spontaneous cholecystocutaneous fistula. South Med J 2004;97:183-5.
5. Morissey KP, McSherry CK. Internal biliary fistula and gallstone ileus. In: Czerniak A, Blumgart LH, editors. Surgery of the Liver and Biliary Tract. Vol. 1. Edinburgh: Churchill Livingstone; 1994.
6. Czerniak A, Blumgart LH. External biliary fistula. In: Czerniak A, Blumgart LH, editors. Surgery of the Liver and Biliary Tract. Vol. 1. Edinburgh: Churchill Livingstone; 1994.

Case Report

A rare case of laryngeal tuberculosis simulating malignancy

Rajat Agarwal, Javed Khan, Shubham Jain

Department of Pulmonary Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

Corresponding Author:
Subham Jain, Department of Pulmonary Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India.
E-mail: shubham.edo@gmail.com

Received: 05-04-2020
Accepted: 20-04-2020
Published: 30-04-2020

How to cite this article:
Agarwal R, Khan J, Jain S. A rare case of laryngeal tuberculosis simulating malignancy. Int J Adv Integ Med Sci 2020;5(2):64-66.

Source of Support: Nil,
Conflicts of Interest: None declared.

Laryngeal tuberculosis accounts for <1% among patients of tuberculosis and is most often associated with primal lung infection[1] In many cases, it is laryngoscopy features mimic malignancy. We illustrate the difficulty of recognizing laryngeal tuberculosis both clinically and radiologically in a 60-year-old man who presented with the clinical picture of laryngeal mass which turned out to be tuberculosis on histopathology.

KEY WORDS: Culture, antitubercular therapy, tuberculosis

INTRODUCTION

The laryngeal tuberculosis occurrence has been greatly decreased as a result of improvement in public healthcare and development of effective anti-tuberculosis chemotherapy. Tuberculosis of the larynx is commonly secondary to a tuberculous lesion elsewhere in the body or rarely a primary affection from inhaled tubercle bacilli directly. The extra-pulmonary involvement of tuberculosis ranges from 30% to 40%.[2] Recently, on attempting to rule out carcinoma, tuberculosis of larynx has been diagnosed by clinicians.[3] This case report discusses a proliferative growth in the epiglottis, clinically mimicking a malignancy.

CASE REPORT

A 60-year-old male, farmer by occupation presented with a 2 years history of productive cough that increased in 2-months, shortness of breath since 2 months, hoarseness of voice and difficulty in swallowing since 15 days. There was no history of fever, chest pain, stridor, or any contact with a case of tuberculosis.

Difficulty in swallowing, hoarseness and chronic cough are the main symptoms in patients suspicious of laryngeal carcinoma. The patient was a chronic smoker (28 pack-years) with no alcohol and drug abuse. Patient had a history of tuberculosis 2 years back on sputum basis for which he took ATT for 6 months and got bred.

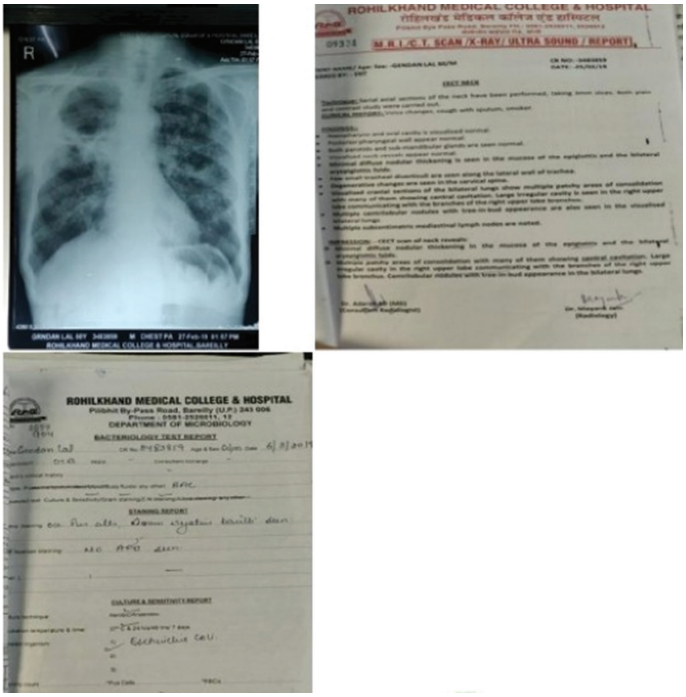
On general physical examination, patient was conscious, thin built and non-febrile. There was no cervical lymphadenopathy or clubbing. There were no scar marks or sinuses in the neck. Indirect laryngoscopy showed a greyish tumor in the left supraglottic region. Vocal folds were moving with no signs of infiltration.

Examination of respiratory system showed bilateral coarse crepts in suprascapular region. Rest of the systems were within normal limits.

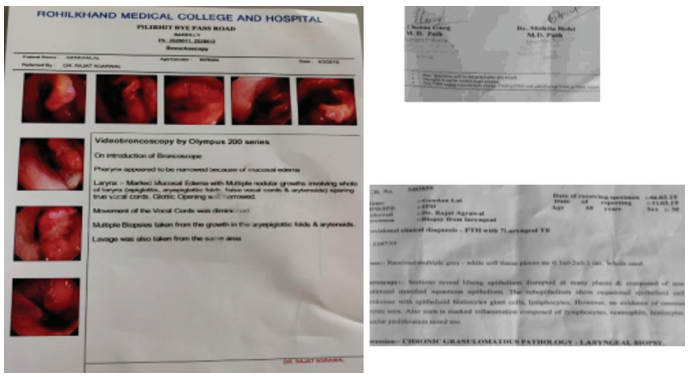
A plain chest radiograph (CXR) and computed tomography (CT) scans of the neck and thorax were performed. The CXR showed bilateral reticulonodular infiltrative lesions in the upper zones.

Access this article online	
Website: www.ijaims.net	Quick Response code

Contrast-enhanced CT scan of the neck was performed on which revealed thickening and enhancement of the epiglottis and both aryepiglottic folds, the pyriform fossae, and both vocal cords, including the anterior commissure. There was a predominant anterior pattern of involvement, against a diffuse background of multiple, focal, low-attenuation areas, and obliteration of the para laryngeal fat planes. Multiple sub centimetric lymph nodes were also noted. CT scan of the chest confirmed the CXR findings and showed large irregular cavity in the right upper lobe. Sputum examination was negative for acid-fast bacillus (AFB) and was proceeded with cartridge-based nucleic acid amplification test and AFB C/S.



Direct laryngoscopy was done and biopsy was taken from epiglottis and inter arytenoid region. The specimen was sent for histopathological examination. Based on these findings, laryngeal and pulmonary reactivation TB diagnosis was made and the patient was started on standard anti-tuberculosis treatment of four drugs. Initially, he responded well to the treatment, and by 3 weeks he was symptom free. Laryngoscopy showed resolution of the inflammatory changes in supraglottic region and he was discharged with instructions to complete the anti-tubercular treatment. The patient remained stable on routine follow-up visits for 1 year.



DISCUSSION

Upper respiratory tract tuberculosis is an uncommon entity with incidence of laryngeal tuberculosis <1% of all cases of tuberculosis.[5] Rohwedder founded only 11 laryngeal cases (1.3%) in 843 tuberculosis patients.[7] The pathogenesis can be primary or secondary of laryngeal involvement.[5] In the present case, the pathology was probably secondary to pulmonary infection.

Laryngeal tuberculosis has predominant occurrence in individuals of 40–60 years with gender ratio 2:1–3:1.[8]

Tuberculosis that is isolated to head and neck region is commonly seen in patients with HIV infection and therefore should be kept as differential diagnosis of all the lesions of head and neck even in the absence of lung involvement. Alonso *et al*. reported 11 cases with the dominant symptom as dysphonia in 82% cases, either alone or accompanied by odynophagia or dyspnea.[11]

In the present case, hoarseness of voice was the main symptom. The main symptoms are difficulty in swallowing, hoarseness, and chronic cough in suspected patients of laryngeal carcinoma. For establishing a definitive diagnosis, biopsy and direct laryngoscopy are mandatory.[9] Epithelioid granuloma with Langerhans type giant cell, granulomatous inflammation, and caseating granuloma formation are characteristic features of this type of tuberculosis.[2] Tuberculosis and malignancy both can coexist in the same patient.[5] Therefore, as in our case, the diagnostic challenge is to exclude the laryngeal cancer first. The anti-tubercular therapy generally cures the disease without any sequel and gives good prognosis. As in our case, most lesions disappear over a 2-month period.

The disease has been changing its behavior in many ways and nowadays, clinicians differential diagnosis of the both upper and lower respiratory tract pathologies should have a tuberculotic lesion. Worldwide, the incidence of tuberculosis has been increasing. Therefore, tuberculosis of the larynx must be suspected in patients presenting with dysphagia and odynophagia that mimics a laryngeal carcinoma.

REFERENCES

1. Uslu C, Oysu C, Uklumen B. Tuberculosis of the epiglottis: A case report. Eur Arch Otorhinolaryngol 2008;265:599-60l.
2. World Health Organization. Guidance for National Tuberculosis Programmes on the Management of Tuberculosis in Children. Geneva: World Health Organization; 2014.
3. Pillsbury HC 3rd, Sasaki CT. Granulomatous diseases of the larynx. Otolaryngol Clin North Am 1982;15:539-51.
4. Epeli E, Ophan F, Alper M, Harputluoglu U, Bulut I. Epiglottic tuberculosis in a patient treated with steroids for Addison's disease. Tohoku J Exp Med 2003;201:119-25.
5. Una1 M, Dusmez D, Gorur K, Aydin O, Talas DU. Nasopharyngeal tuberculosis with massive cervical lymphadenopathy. J Otolaryngol 2002;31:l86-8.

6. Rohwedder JJ. Upper respiratory tract tuberculosis. Sixteen cases in a General hospital. Ann Intern Med 1974;80:708-13.
7. Galli J, Nardi C, Contucci AM, Cadoni G, Lauriola L, Fantoni M. Atypical isolated epiglottic tuberculosis: A case report and a review of the literature. Am J Otolaryngol 2002;23:237-40.
8. Moon WK, Han MH, Chans KH, Kim HJ, Im JG, Yeon KM, *et al*. Laryngeal tuberculosis: CT findings. AJR Am J Roentgenol 1996;166:445-9.
9. Alonso PE, Mateos AM, Perez-Requena J, Serrano EA. Laryngeal tuberculosis. Rev Laryngol Otol Rhinol 2002;14:352-6.