



Cholecystitis With Accessory Cystic Duct - A Case Report

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ABSTRACT

Acute cholecystitis is commonly caused by cystic duct obstruction, but unrecognized anatomical variants, such as an accessory cystic duct, can cause significant pathological variations and surgical complications. We report a case of a 40-year-old male who underwent laparoscopic cholecystectomy for cholecystitis. Despite the successful clipping of the primary cystic duct and artery, the patient presented on the 19th postoperative day with biliary peritonitis. Diagnostic laparotomy and subsequent ERCP revealed a persistent leak originating from an accessory cystic duct. Given that approximately 10% of the population possesses anomalous biliary anatomy, this case highlights the clinical importance of identifying aberrant ducts to prevent delayed biliary peritonitis and the necessity of secondary surgical intervention.

KEYWORDS-

Accessory Cystic Duct , Cholecystitis, Biliary Peritonitis,

Laparoscopic Cholecystectomy, Anatomical Variation ,

ERCP .

INTRODUCTION

Acute cholecystitis occurs secondary to obstruction of cystic duct or common bile duct resulting in bile stasis with inflammation and oedema of the gall bladder wall. Nevertheless unrecognised anatomical variants of the cystic duct may cause different pathological disease variation in gall bladder disease. A 40yr male patient with chief complaints pain in abdomen afterwards was Provisionally diagnosed as cholecystitis on table was found with rare presentation of accessory cystic duct.

Objectives: To Study of the Surgical Management of Cholecystitis with Accessory cystic duct with a single case study.

Case Report:

Name-xyz.

Age-40yr. Gender Male.

Religion-Hindu.

Occupation-Worker.

Main Complaints and Duration-

Pain in abdomen at Right Hypochondriac region since 15 days. Vomiting once in a day.

Nausea++.

Having Fever for 4 days.

Past History -Not any Surgical History,

Medical History - Not known case of DM/ HTN/Asthma/Koch's.

Family History-Nothing specific Family History.

Physical Examination

GC- fair and afebrile

Pulse-82/min

BP-120/80 mm of Hg.

CVS-S1-S2 Normal

CNS-concious Oriented

RS- AEBE clear and Normal.

P/A-tenderness At Rt Hypochondriac region.

Bowel-Passed, Micturition-Clear.

General Examination - No pallor, No Icterus, No

regional Lymphadenopathy.

Local Examination –

On local examination demonstrated a Soft abdomen with tenderness in Rt Hypochondriac and epigastric region. No obvious Mass was observed on palpation.

INVESTIGATION –

haematological Tests were Carried out which Showed Hb-12 gm, WBC-11000/cumm differential Count Showed N-70 %L-20% E-3%M-3% Basophiles-2%.

Urine Normal,

Renal Function-Normal,

LFT - Total Bilirubin 0.67 mg/dl, Direct-0.2 mg/dl, indirect 0.47 mg/dl, Alkaline Phosphatase 68 U/L

Rest investigations likes BSL and Serology reported Normal.

ECG, chest x-ray-normal. HIV-Negative HbsAg Negative.

USG-abdominal and pelvis showed - Multiple G.B. Stones of 4 to 5 mm in size with Changes of Cholecystitis. No intrahepatic biliary Radicle dilatation seen and CBD of normal dimension.

TREATMENT AND MANAGEMENT

Conservative Management started with intravenous Fluids, Antibiotics, Inj. Supacef 1.5 gm IV BD, Inj. Metrogl 500 mg IV TDS and Analgesics with Nasogastric aspiration done and posted for laparoscopic Cholecystectomy.

SURGICAL PROCEDURE-

Anaesthesia-General Anaesthesia.

Position supine position, under all aseptic precautions, Painting and drapping was done.

Gall bladder was found distended, also few omental adhesion was found adhesionolysis was done with the help of cautery for the same. Callots triangle dissection was done to identify and dissect cystic artery and cystic duct. An additional Cystic node was also cauterized. The dissected Cystic duct and artery was clipped proximally and distally with the help of two clips on each ends and cut in the middle of both ends. The partially separate gallbladder from duct and artery was then separated from liver bed completely by confirming perfect haemostasis.

The specimen was taken out then.

Follow Up

Vital Parameters monitored.

Gradually patient shifted on liquid-Semisolids and normal diet on 3rd day. The drain was observed it also reduced from 50 ml to 5 ml in three days patient was kept on antibiotics and analgesics Paranterally for three days. As patient has normal bowel. The drain was removed on 4th day and shifted on oral Antibiotics Tab. Augmentin 625 mg 1 BD, Tab. Pan 40 mg 1 OD, Tab. Arflur- P 1 BD-for five days and discharged.

On first F/U Patient was found Asymptomatic, the Port site wounds were healed and sutures were Removed.

On 19th post operative day patient came to hospital C/o Pain in abdomen, Abdomen distension was on physical examination, Pain at port was site, peristalsis ++, BP, Pulse, NAD, ultra sound examination carried observed biliary peritonitis was noticed. Haematology was done. Everything found normal IV Inj. Monocef

1 gm iv BD, Inj. Metrogyl 500 mg IV TDS, Inj. pan 40 mg iv OD and iv fluids were started. Abdomen tapping was done GOLDEN BILE ASPIRATED was taken for Diagnostic Laparotomy explored by upper abdomen midline incision near about 1.5 lit. bile sucked rest of abdomen examination done, No biliary tract injury was seen clips. applied to cystic duct was found in situ lavage given. Abdomen drain No. 28 was kept, fixed and Layerwise abdomen closure was done same treatment was continued for next three days gradually patient was shifted on oral medication and diet but GOLDEN BILE DRAIN REMAINS OFF about 250 ml to 300 ml every day in post operative period, Finally considering biliary leak patient posted for ERCP procedure and Miracle seen on 3rd post operative day the drain stopped and drain was removed. so it was Accessory Cystic duct which was trickling.

DISCUSSION AND CONCLUSION

As 10% of population have anomalous biliary tree anatomy. It was surprising to find that the variant described in the above case. It is important not to assume that aberrant ducts such as the ones described are of no consequences. Because of abnormal duct presentation (anatomical variation) patient showed above symptoms, delayed biliary peritonitis and surgical intervention was needed.

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