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Cholecystocolonic Fistula: Surgical Dilemma

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Background : The cholecystoenteric fistulas are an uncommon but pertinent complication of gallbladder disease occurring in 0.06% - 0.14% of patients with biliary disease.1 Among the different types of cholecystoenteric fistulas, the cholecystoduodenal is the most common with cholecystocolonic fistulas being the second most common.2 Cholecystocolonic fistulas are most commonly discovered intraoperatively during cholecystectomy, being diagnosed in 0.5%.3 The underlying pathophysiology is related to chronic inflammation due to gallstones; however other mechanisms have been described including gallbladder malignancy, previous gastric surgery, previous cholecystostomy and penetrating abdominal wounds.4 Failure to identify these fistulas can be catastrophic.

Methods : N/A - case report

Results : A 59-year-old man presented to the emergency department complaining of abdominal pain localized to the right upper quadrant, described as crampy, non-radiating, with a pain rating score of 5 out of 10. No other associated symptoms such as fever, nausea, vomiting, changes in stool color noted. The patient's history was significant for hypertension and diabetes. On physical examination, there was direct right upper quadrant tenderness and murphy's sign. Laboratory result was remarkable for the following values: white blood cell count of 19.25 x 109 cells/L, neutrophils 0.86, alkaline phosphatase of 166 U/L, and direct bilirubin of 7.01 umol/L. A magnetic resonance imaging of the abdomen confirmed the presence of a possible gallbladder sinus tract formation with liver and fistulous tract formation with the transverse colon (Figure 1). The patient underwent open cholecystectomy with frozen section, right hemicolectomy revealing a gangrenous gallbladder with fistulous tract communicating to the proximal transverse colon. Severely inflamed distal and proximal transverse colon. Final histopathology report revealed a gangrenous cholecystitis with granulation tissue formation, fibrosis, fat necrosis, and hemorrhage, consistent with fistulous formation. Colonic segment with focal acute on chronic inflammation, granulation tissue and fibrinous sclerosis, consistent with fistula tract. His postoperative course was unremarkable, patient was discharge on the 4th post-operative day.

Conclusions : In conclusion, while the presence of Cholecystocolonic fistula is atypical, the surgical dictum highly depends on the overall clinical picture of the patient and whether or not the patient is a good surgical candidate.

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