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Case Report

Chronic right lumbar suppuration following stone forgotten during laparoscopic cholecystectomy

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ABSTRACT

The breaking of the gallbladder during laparoscopic cholecystectomy east of a common event, and usually harmless, even if stone are missed. Exceptionally these calculations are causing persistent suppuration and may pose therapeutic problems. We report the case of a woman who presented a chronic suppurative the right lumbar pit months after laparoscopic cholecystectomy. This illustrates the observations difficult diagnosis of this rare complication and providing imaging. as in our case, surgical removal of the calculi is the only way to ensure healing.

Keywords: Chronic suppuration, Laparoscopic cholecystectomy, Missing stone

INTRODUCTION

The laparoscopic cholecystectomy is now considered the treatment of choice for symptomatic gallbladder stones.

This surgical procedure allows more aesthetic scars, less postoperative pain and earlier transit recovery. Hence, it can be considered a simple operation, but can also lead to many complications.[1]

The perforation of the gallbladder and the gallstones spillage into the peritoneal cavity are the two most common complications in the laparoscopic cholecystectomy.[2]

Forgetting calculi in the abdominal cavity is deemed insignificant. Exceptionally these calculi are causing persistent suppuration which may pose therapeutic problems.

We report, in this work, an extremely rare case of gallstone lost in the peritoneal cavity complicated by a sub-liver abscess fistulized to the skin.

CASE REPORT

We report the case of a 64-year-old obese female patient (BMI 41) operated by laparoscopy for acute gallstone cholecystitis. The patient was operated 8 months later for a large parietal abscess at the right lumbar region. She returned after three months for appearance of a fistula orifice in the center of the flattening scar. Given the persistence of the fistula, the surgical exploration showed a complex fistula extending from below the ribs to the intra-abdominal area.

The complete removal of the tract was not possible, hence, an early postoperative recurrence of the fistula.

The exploration by CT and MRI showed a collection at the Morrison level centered by a calculus with multiple sinus tracts from the collection (Figures 1 and 2).

The patient was re-operated. She had an incision by orange quarter, excision of the fistula tract after osteotomy of the last right rib and removal of an 0.5 cm-diameter calculus located in in the shell of the abscess

(Figures 3 and 4). The postoperative were favorable and healing has been finally obtained.

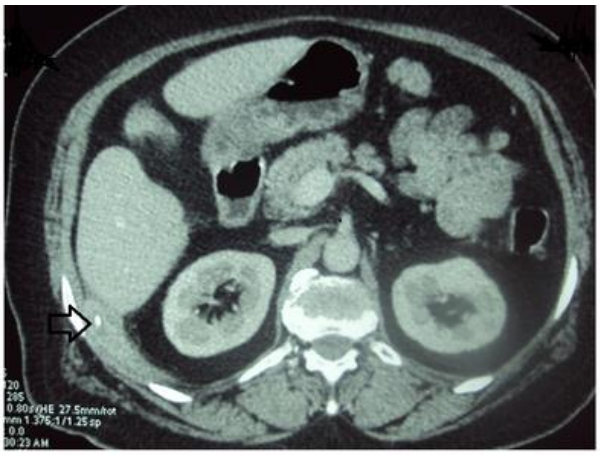

Figure 1: Collection at the Morisson level centered by a calculus.

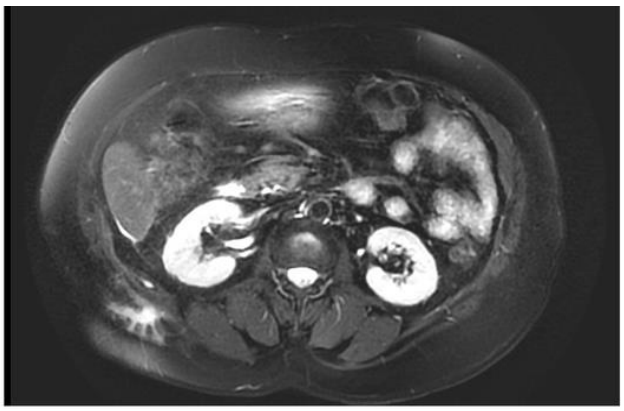

Figure 2: Inflammatory subcutaneous nodule of the posterior abdominal wall fistulized to the skin and communicating with an intramuscular collection of the oblique muscle.

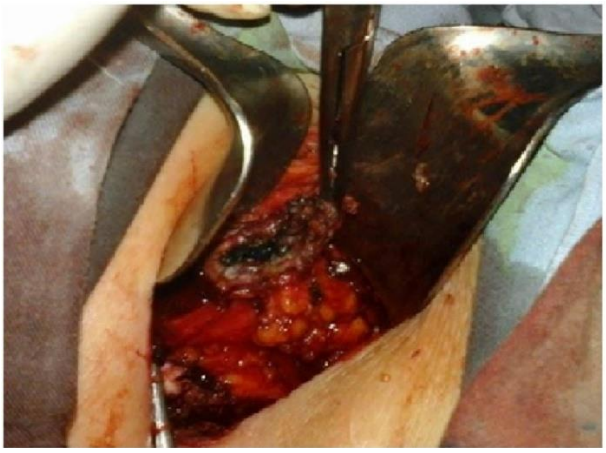

Figure 3: Abscess in the morisson space whose shell contains an 0.3 cm calculus.

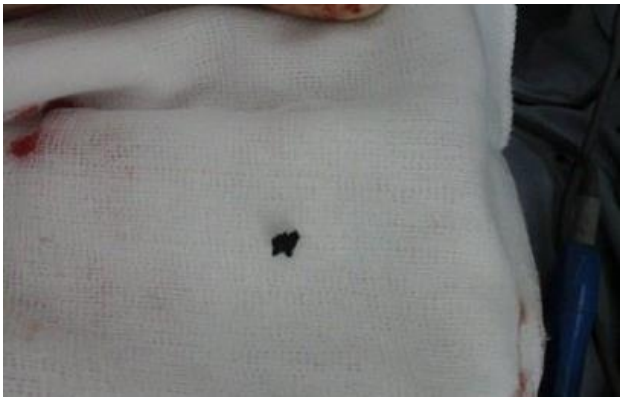

Figure 4: 0.3cm-diameter calculus responsible of a sub-hepatic abscess.

DISCUSSION

The laparoscopic cholecystectomy has become the treatment of choice for symptomatic gallbladder stones in the past three decades.[1]

Given that surgeons have become more experienced, several studies have shown a marked decrease in the frequency of complications of laparoscopic cholecystectomy but remain higher than those of the classical pathway cholecystectomy.[2]

The most frequent complications during a laparoscopic cholecystectomy include perforation of the gallbladder and intraperitoneally-spilled calculi, the incidence of these complications is estimated between 10 and 30%.[3,4]

Most spilled and lost calculi in intra peritoneal do not cause problems and give no complications. They are often found incidentally during practice of standard X-rays or scanners for other reasons.[5,6] The rate of abdominal complications reported after removal of calculi in intra peritoneal is estimated at 1.4% according to a Swiss retrospective analysis.[7]

These complications include abscesses in the abdominal wall, sub-phrenic abscess and sub-hepatic fistula, dehiscence, hernia and tumors containing calculi. The risk factors of appearance of these complications described in the literature are: the presence of acute cholecystitis (infected bile), the nature of the calculi (pigment stones), size (greater than 1.5 cm) and number.[8,9]

To prevent these complications, some recommendations should be followed in case of perforation and intra peritoneal calculus spillage: a complete peritoneal wash with saline, removal of the maximum amount of dumped stones using a good aspiration.[8,9]

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