Case Report

A diagnostic challenge

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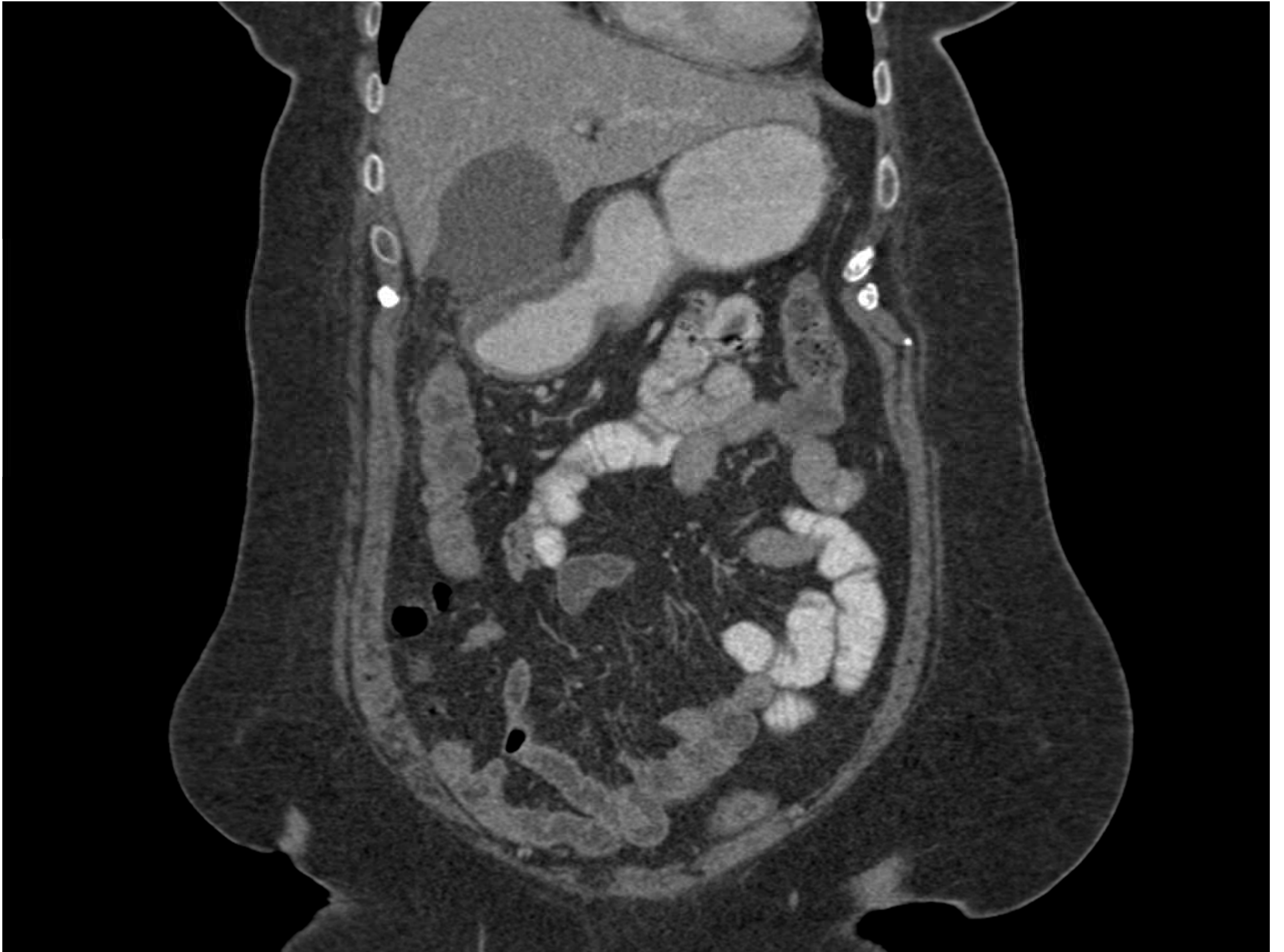
Presentation

- 63 female; Diabetic (NIDDM)
- Upper abdominal pain and fever for 24 h
- Leucocytosis
- Uss – Distended but non thickened gallbladder; no stones
- CT scan – Distended gallbladder but no evidence of cholecystitis;

  Thickened wall of antrum suggesting severe gastritis
- Gastroscopy – severe gastritis with erosions



Management

- Rx PPI
- Cephalosporins
- Msu +ve for e-coli – sens to meropenem
- Antibiotic change
- Dramatic improvement within 48 hours
- Pain resolved and apyrexial within 24 hours
- Tolerating diet

straightforward…

Clinical course

48 hours later – i.e. 4 days after day of admission mild swinging pyrexia again with no abdominal pain or tenderness;

Cardiac echo : NAD

Wcc normal

Plan: Wait and see; in the meantime eating satisfactorily

In summary – the only abnormality is 'PUO' with no other symptoms or signs

Clinical course

On day 7

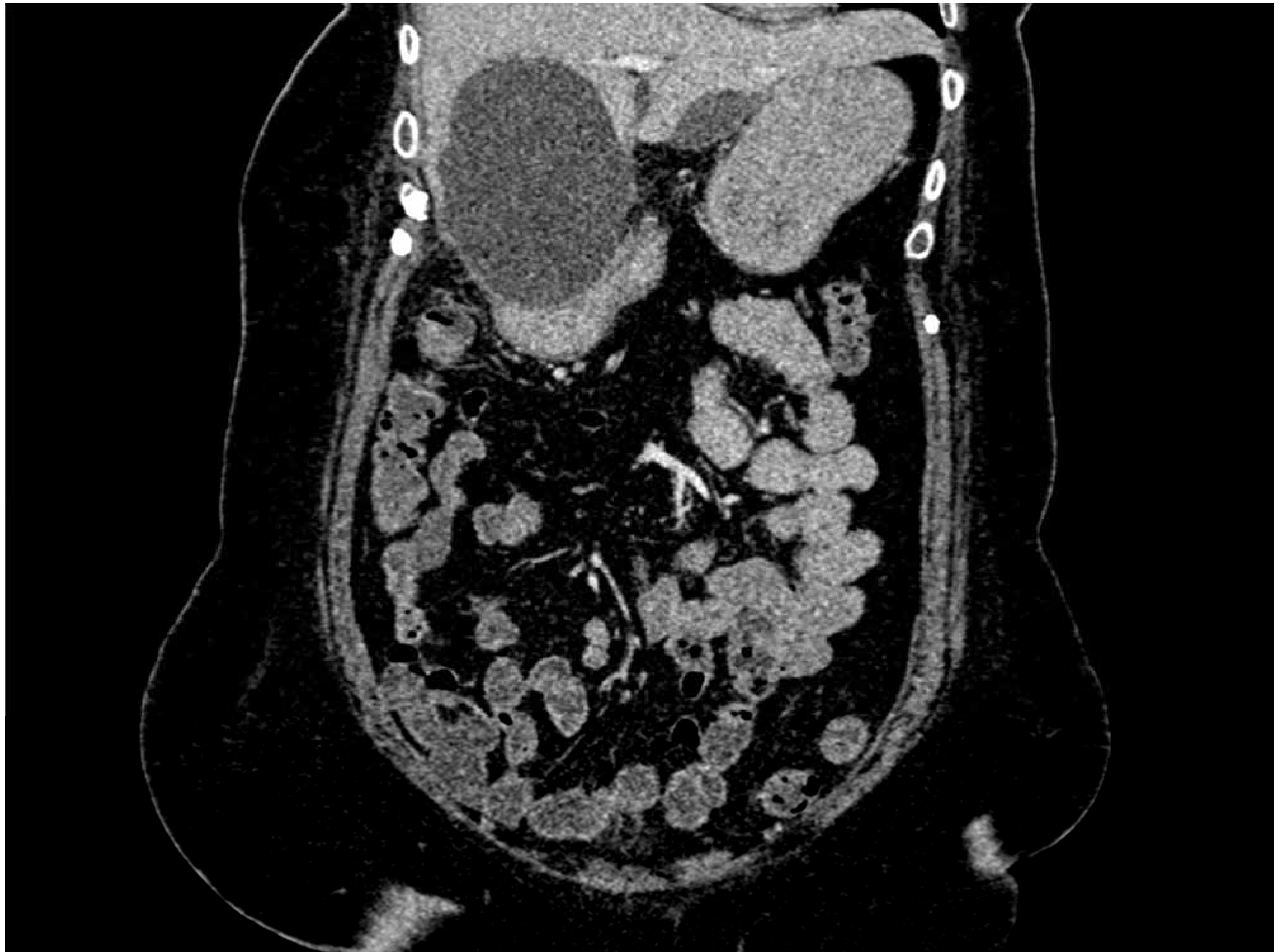
USS of abdomen repeated ; showed very distended thin walled GB with fluid around it

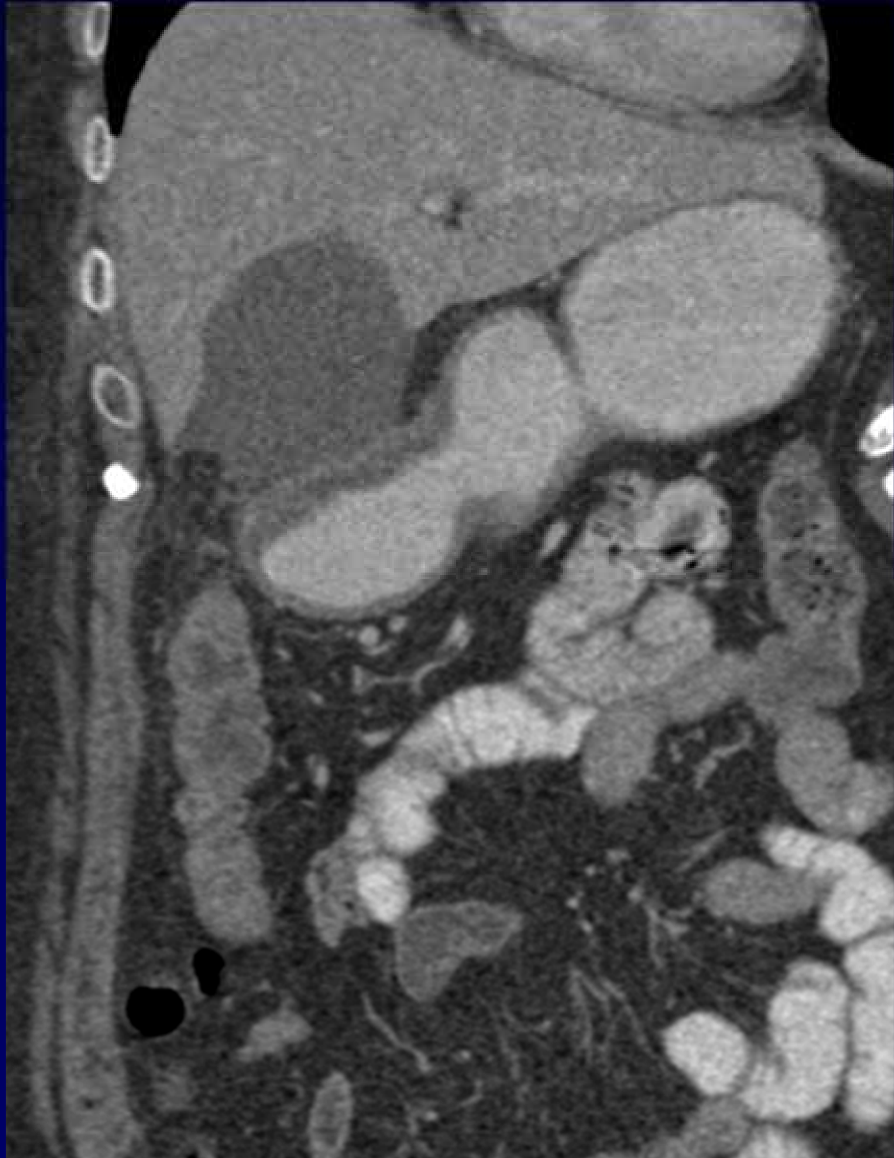
4C-A/ABD
15.0cm / 41Hz
TIs 0.1

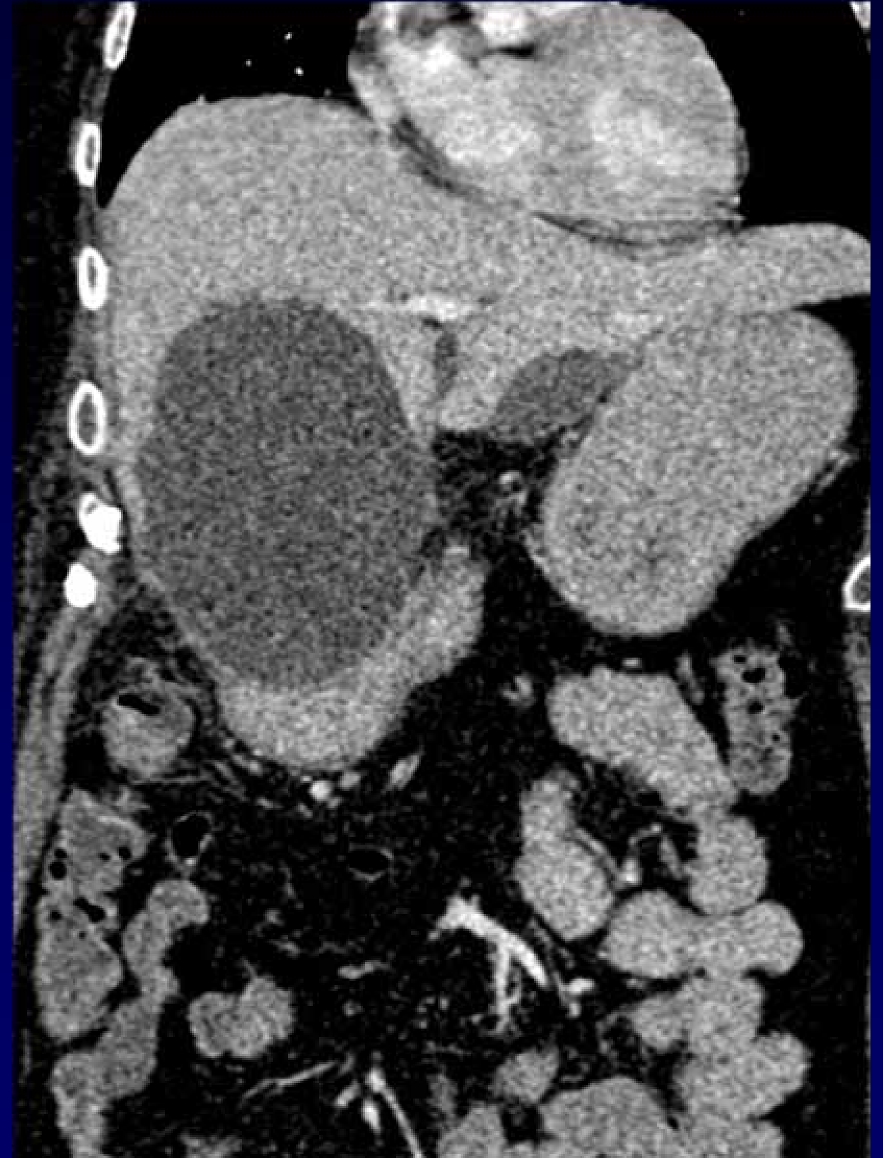
Clinical course

Limited CT carried out; showing increased 'fluid' collection in the region of the gallbladder without really distinguishing the actual wall and extending towards liver medially;

…raising possibility of abscess







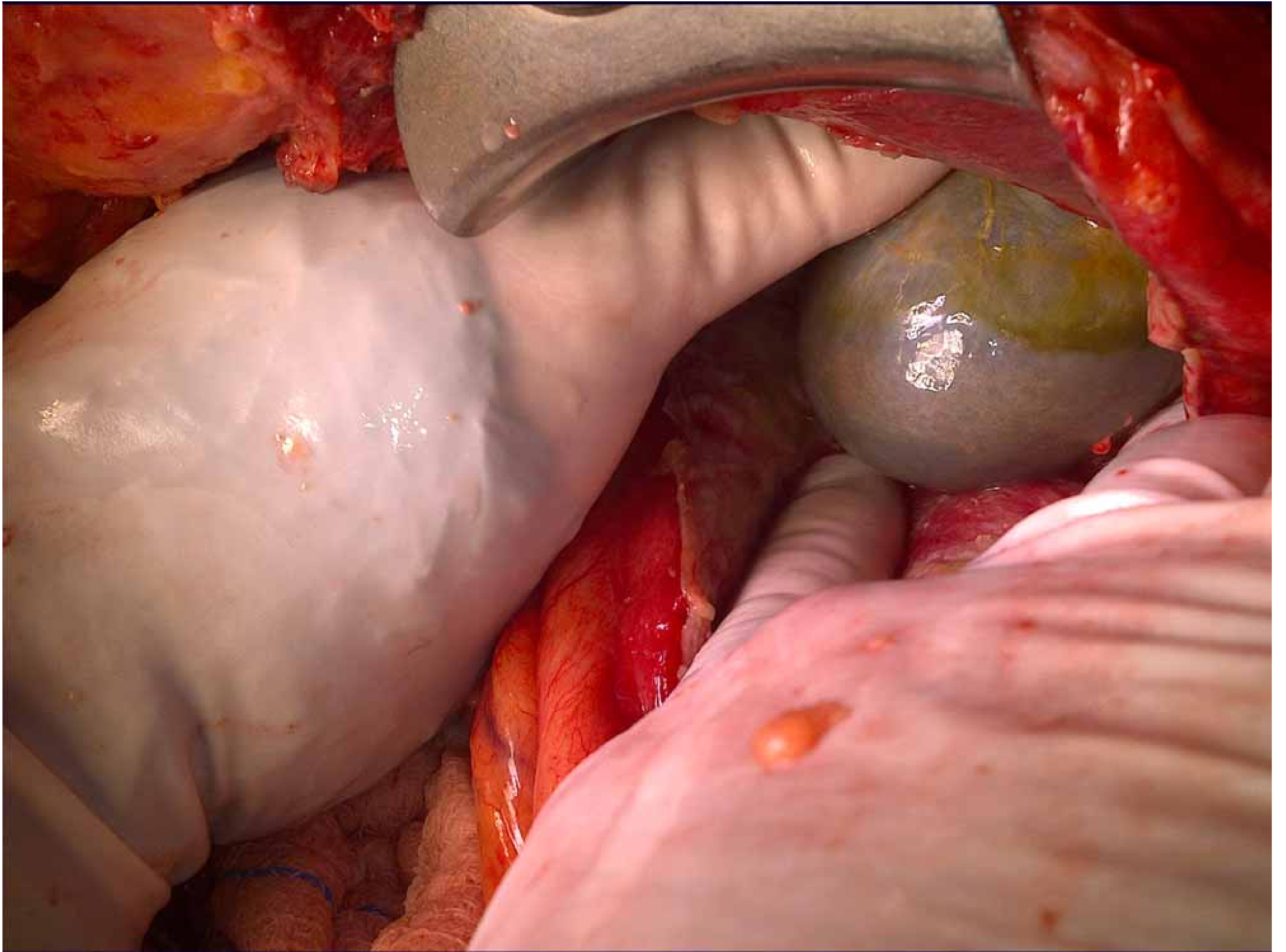
Clinical course

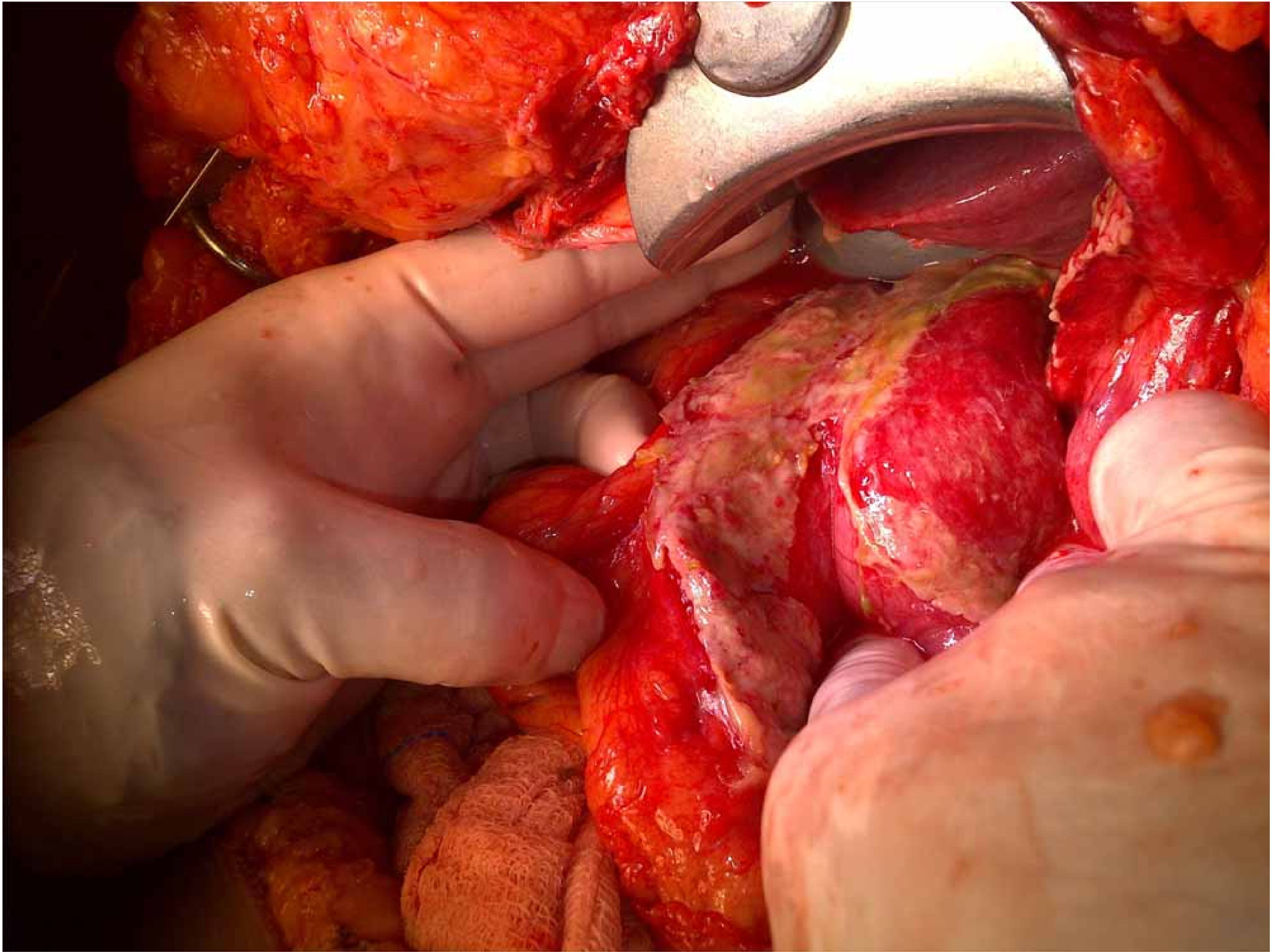
WCC slowly rising and pyrexial again

Decision taken for laparotomy same day…

Findings

- Bilious collection around a very distended gallbladder;
- Walled off by adjacent organs - transverse colon and mesentery; omentum; stomach; duodenum and liver.
- Imprint of slough representing localised peritonitis





Findings

- Initial assessment – ? perf DU which had sealed off
- Air blown in stomach etc – no leak
- GB distended but where did the bile come from ???

Findings

- Bile leaking from GB itself
- GB opened revealing infarction with paper thin walls; No identifiable mucosa
- limp serosal ‘film’ which was on the verge of disintegrating
- Cholecystectomy (no stones)

Post-Operative Course

- Slow and gradual recovery
- Apyreaxial from day 1 post –op
- Discharged 7 days later
- Review OPD 2 weeks later ; doing very well

Gallbladder infarction

- Thin walled complete infarction – primary event due to thrombosis of cystic artery or embolus; very rare indeed
- PUBMED search less than 10 reports
- No inflammatory response or ‘cholecystitis’
- *1963- a first report secondary to arteriosclerotic occlusion cystic artery*
- *Transcatheter chemoembolisation; subacute infective endocarditis; celiac angiography; neonatal umbilical artery catheterisation; post renal transplantation*

Gallbladder infarction

- Contrast with gangrenous GB secondary to cholecystitis and ischaemia associated with cholelithiasis
- Thick walled
- very commonly seen

Conclusion

- Keep questioning your diagnosis
- Re-evaluate original findings; test results etc
- Do not be afraid to order same tests again
- In this particular case; thin wall GB with no stones *but* increasing fluid around it turned out to be the clue
- In retrospect, 'absence' of gallbladder 'wall' on CT correlated with an infarct and non enhancement after contrast administration