Dear Editor,

We present the case of a 58-year-old man with a history of a heavy alcohol intake who was admitted to the hospital with a 3-week history of abdominal discomfort, nausea, vomiting and an increased abdominal girth that appeared progressively after an abdominal trauma due to an accidental fall. On physical examination, jaundice was present and the abdomen was distended predominantly on the right side with no tenderness on palpation. Laboratory studies showed an increased white-cell count of 11.8x10⁹ per liter, a C-reactive protein level of 4.5 mg/dl (normal < 0.5) and abnormal liver-function tests: Alanine aminotransferase 102 U/l (normal < 41), aspartate aminotransferase 63 U/l (normal < 40), alkaline phosphatase 255 U/l (normal < 130), gammaglutamyl transpeptidase 275 U/l (normal < 60), total bilirubin 2.66 mg/dl (normal < 1.2) and direct bilirubin 1.18 mg/dl (normal < 0.2). Abdominal ultrasonography revealed a large fluid collection in the right side of the abdomen. Testing of the fluid showed a white-cell count of 20 cells per milliliter, a C-reactive protein level of 28.52 mg/dl and a serum-ascites albumin gradient of 32.6 g/l. An abdominal computed tomography scan revealed a gallbladder perforation communicating to a big subcapsular hepatic biloma of 9.5 by 25.0 by 35.0 centimeters, which was compressing the liver and other intraabdominal organs (Fig. 1). Finally, our patient underwent an open cholecystectomy with drainage of the biloma. Macroscopic and microscopic examina-
tion of the resected specimens confirmed the diagnosis of traumatic gallbladder perforation.

Discussion

Gallbladder traumatic injury is a rare entity. Its incidence in patients with abdominal blunt trauma is around 2% (1). The swelling or distension of the gallbladder wall and alcohol consumption are the main risk factors, since both are associated with an increased biliary tract pressure (2). They can be classified as contusion, perforation and avulsion, which can be partial when there is no bile duct or vessel damage or complete when both structures are thorn, producing the so-called “traumatic cholecystectomy” (3). The diagnosis represents a challenge because of its low incidence, its association with other lesions of vital organs and the nonspecific and insidious symptoms that can produce. The increasing availability of diverse modern imaging techniques such as the multislice computed tomography, have allowed physicians to detect this injuries at earlier stages. Treatment depends on the type and severity of the damage caused; nevertheless, cholecystectomy remains the treatment of choice in patients with rupture or avulsion of the gallbladder.

The insidious clinical presentation of our patient resulted in a late diagnosis and in fact, he was initially wrongly diagnosed as a new-onset ascites until computed tomography scan was performed. Nevertheless, our patient is being able to maintain a fully active life six months after surgery. To our knowledge, this is the first report in the English literature of an isolated blunt traumatic gallbladder injury that was associated with the development of a large biloma.

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