Letters to the Editor

Hemocholecyst: A rare cause of acute abdomen

Key words: Hemocholecyst. Hemoperitoneum. Jaundice.

Dear Editor,

We present a case of acute abdomen with hemoperitoneum and high gastrointestinal bleeding due to a hemocholecyst.

Case report

A 85-year-old woman with a medical history of diabetes mellitus, hypertension and atrial fibrillation treated with warfarine. She went to the emergency room for abdominal pain in upper right quadrant, mucocutaneous jaundice and melena. On admission, laboratory examinations showed increased levels of total bilirubin 2.02 mg/dL, direct bilirubin 1.66 mg/dL, aspartate aminotransferase 360 IU/L and alanine aminotransferase 207 IU/L with normal levels of amylase (46 IU/L). She had leukocytosis with decreased hemogram (hemoglobin 7.3 g/dL and hematocrit 23%). Abdominal ultrasound reported an acute cholecystitis with cholecystitis and she was admitted in the Hospital for treatment.

During admission, she presented an episode of acute abdominal pain with abdominal distension, melena and hemodynamic destabilization. Fluidotherapy was started and she needed blood transfusion. A gastroscopy was performed, that showed clots in stomach and duodenum without observing the cause of the bleeding. Due to the persistence of gastrointestinal bleeding, a CT-angiography was made which showed hemoperitoneum and distended gallbladder that contained a high attenuation material inside with a possible leak of contrast leakage and a discontinuity of the gallbladder wall, which was suggestive of perforation (Fig. 1).

Emergency surgery was performed due to the patient clinical status. Intraoperatively, a 3-liter of hemoperitoneum and a perforated gallbladder were found. The cause of the bleeding was a polyoid lesion inside the gallbladder. Cholecystectomy, clot extraction of bile duct and T-tube drainage trans-cystic was performed.

After surgery, the patient’s symptoms improved and she was discharged on the 8th day postoperative.

Discussion

A hemocholecyst is a clot-filled gallbladder caused by bleeding into its lumen. The term HC was first introduced in 1961 by Fitzpatrick (1), and since then, few cases have been described in the literature. It has many causes including gallbladder trauma, iatrogenic manipulation, biliary tumors, parasites, ischemia, cystic artery aneurysm or neighboring arteries or coagulation disorders (2-4).

HC clinic depends on the amount of bleeding or the presence of clots. Normally, presents as biliary colic pain, jaundice and...
gastrointestinal tract hemorrhage. If the bleeding reaches the digestive tract through the bile duct, the patient can refer melena or hematemesis. Clots on the biliary tree may cause obstructive jaundice or pancreatitis (5).

Although diagnostic tests such as abdominal ultrasound, CT-scan or MRI are good techniques to identify the gallbladder, the preoperative diagnosis is difficult. The US can show a gallbladder full of clots or echogenic material with a dilated biliary ducts and false images inside of lithiasis. CT-scan shows high density material in a distended gallbladder. Sometimes, findings can simulate a gallbladder cancer or a gallbladder hydrops with cholelithiasis (6,7). The differential diagnosis of this clinical (jaundice, abdominal pain and gastrointestinal bleeding) should be made with pathologies such as hepatic artery pseudoaneurysm or cystic, hemorrhagic cholecystitis or gallbladder neoplasms among others (8,9). In fact, there is a great confusion between the HC and the hemorrhagic cholecystitis. In the first one, the clots in the gallbladder lumen cause a wall inflammation and in the second one, the inflammatory process caused by lithiasis produces rupture of the mucosae causing bleeding inside the gallbladder (4).

Cholecystectomy is the elective treatment, open or laparoscopic, depending on the clinical presentation (2,10). Due to our patient’s clinical state and the hemoperitoneum we decided to perform emergency cholecystectomy through a midline laparotomy to a make proper exploration of the rest of the abdominal cavity.

The HC, although it is not frequently described, it should be considered in patients with gastrointestinal tract bleeding, jaundice and abdominal pain once the most common causes are ruled out, in order to procure an early and a better treatment.

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References