Dorsal inflammatory mass secondary to lost stones after laparoscopic cholecystectomy

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CASE REPORT

We report the case of a 73-year-old man with a medical history of hypertension, diabetes, chronic kidney failure and laparoscopic cholecystectomy in 2013. He was admitted to the Emergency Room in 2016 with a large dorsal abscess of three months evolution without any other symptoms. On physical examination, he had an 8 x 5 cm well defined erythematous, warm, painful, fixed to profound structures and non-fluctuating mass (Fig. 1). The test blood highlighted a 26.80 mg/dl concentration of C-reactive protein (CRP). The computed tomography (CT) scan revealed a retroperitoneal abscess extended to the last ribs and subcutaneous tissue with a calcification in the bottom of the collection (Fig. 2). The surgical notes detailed an incidental gallbladder perforation; subsequently, it was diagnosed as an abscess due to lost lithiasis. We decided to admit the patient for broad-spectrum antibiotic treatment. An interventionist radiologist placed a drain as a guide for the surgical procedure, with extraction of the lost stones and drainage of the collection (Fig. 3).

Fig. 1. Right dorsal mass of approximately 8 x 5 cm. It is a well-defined, erythematous, warm, painful, fixed to profound structures and non-fluctuating mass.

Fig. 2. A. Coronal section: retrohepatic and retroperitoneal collection of approximately 41 x 92 x 87 mm with a calcification in the bottom. B. Transversal section: retroperitoneal collection with a fistulous tract through the abdominal wall towards the subcutaneous tissue. C. Transversal section: pigtail 8F drain in the collection.

Fig. 3. Intercostal incision, drainage and extraction of the lost gallstones (in the Babcock clamp).
DISCUSSION

The most frequent intraabdominal complication after lost stones are abscesses, which account for 65% of complications (1). The main risk factors are: old age, male gender, surgical difficulty, leakage of lithiasis of more than 1.5 cm or more than 15 stones, perihepatic location and pigment-ed gallstones (1-3). The diagnosis requires a high index of suspicion. Cases of spontaneous expulsion of the stones have been reported, but most of them require a definitive treatment via drainage of the abscess and removal of the gallstones in order to prevent recurrences in the future.

REFERENCES