

PICTURES IN DIGESTIVE PATHOLOGY

Choledocho-renal fistula in locally advanced cholangiocarcinoma

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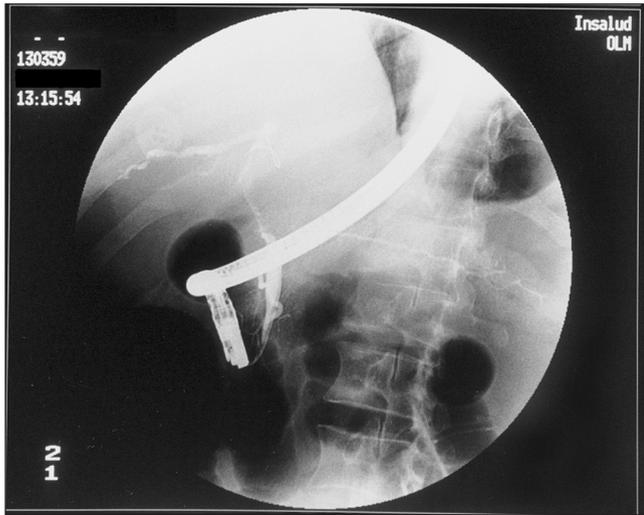


Fig. 1.- The choledochus has an irregular tapering.
El colédoco presentaba una estenosis irregular.

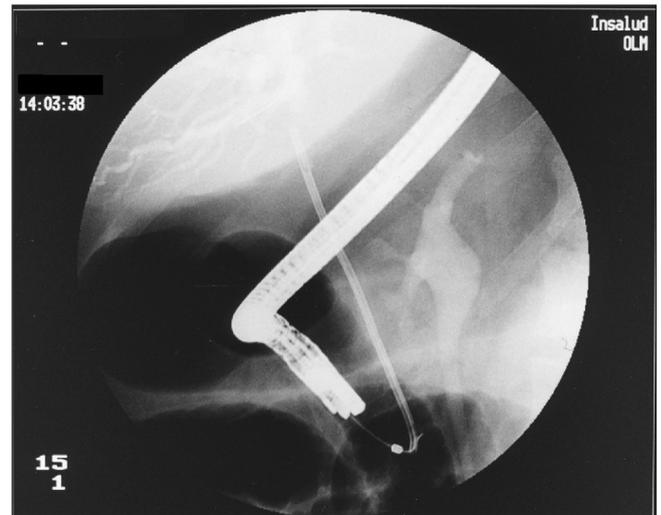


Fig. 2.- A plastic biliary stent is placed within the choledochus.
Se colocó una prótesis biliar plástica en el colédoco.

Choledocho-gastric (1), porta-choledochal (2), choledocho-colonic (3), and cutaneous fistula (4) have been described as complications of cholangiocarcinoma. We report a new kind of biliary fistula as a result of cholangiocarcinoma.

A 56-year-old man underwent ERCP because of progressive jaundice. He had no urinary or other symptoms. His only relevant medical history was a cholecystectomy performed one year before because of acute cholecystitis; operatory cholangiography was normal.

Cannulation revealed a normal pancreatogram. Intrahepatic ducts were markedly dilated, with an irregular tapering in the middle of the common bile duct with a malignant in appearance (Fig. 1). A few seconds afterwards, the radiological image showed the right renal pelvis and ureter filled with the non-absorptive contrast (iohexol) we used. A sphincterotomy was performed, and samples for cytology were obtained with a brush. Then, a 8.5 French and a 10-cm wire-guided stent was placed through the stricture (Fig. 2). The left renal system worked properly and was never filled with contrast. Further films confirmed this finding. Jaundice improved.

Computerized tomography and urine tests showed no alterations. A cytologic diagnosis of cholangiocarcinoma was made. The patient went under expected curative surgery. The tumor, with a 3-cm-long fistulous tract towards the right kidney, was confirmed and then removed by surgery. Carcinomatous cells were found in the excised biliary tract, and in the tissue around it.

Although biliary tumors usually grow slowly and seldom involve adjacent organs, they may sometimes, through circular size increases, affect neighboring tissues by compression, infiltration or fistulation.

These are usually end stages, and treatment is usually endoscopic with biliary stents (5). Surgical treatment can be useful in selected cases.

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