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PICTURES IN DIGESTIVE PATHOLOGY

Bronchobiliary fistula

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CASE REPORT

An 87-year-old man with irrelevant clinical record was admitted to the hospital with a 3-day history of fever up to 39 °C, biliary expectoration and vomiting, together with dysnea. Physical examination showed mildly lowered level of consciousness, tachypnea, basal rhonchi and abdominal distention. Plain abdomen and chest radiographies demonstrated dilation of small bowel loops and right basal condensation, respectively. Scleroatrophic gallbladder with cholelitiasis were detected by abdominal sonography. Biliary content after insertion of nasogastric tube. Thoraco-abdominal computed tomography (CT) confirmed right basal pneumonic infiltrate and subphrenic abscess. Ceftriaxone, gentamicin and metronidazole combination therapy was empirically administered. Vancomycin-sensitive *Enterococcus faecium* growed at an abscess sample culture, so antibiotherapy was changed. Helical three-dimensional CT scan reconstruction performed by constrast injection through previously-implanted percutaneous drainage catether (Fig. 1 A and B, lower arrows) evidenced a bronchobiliary fistula (Fig. 1 A and B, upper arrows), presenting clear pathway between both structures. Laparoscopic cholecistectomy as well as completion of abscess evacuation were carried out. Satisfactory evolution after 6-month follow-up.

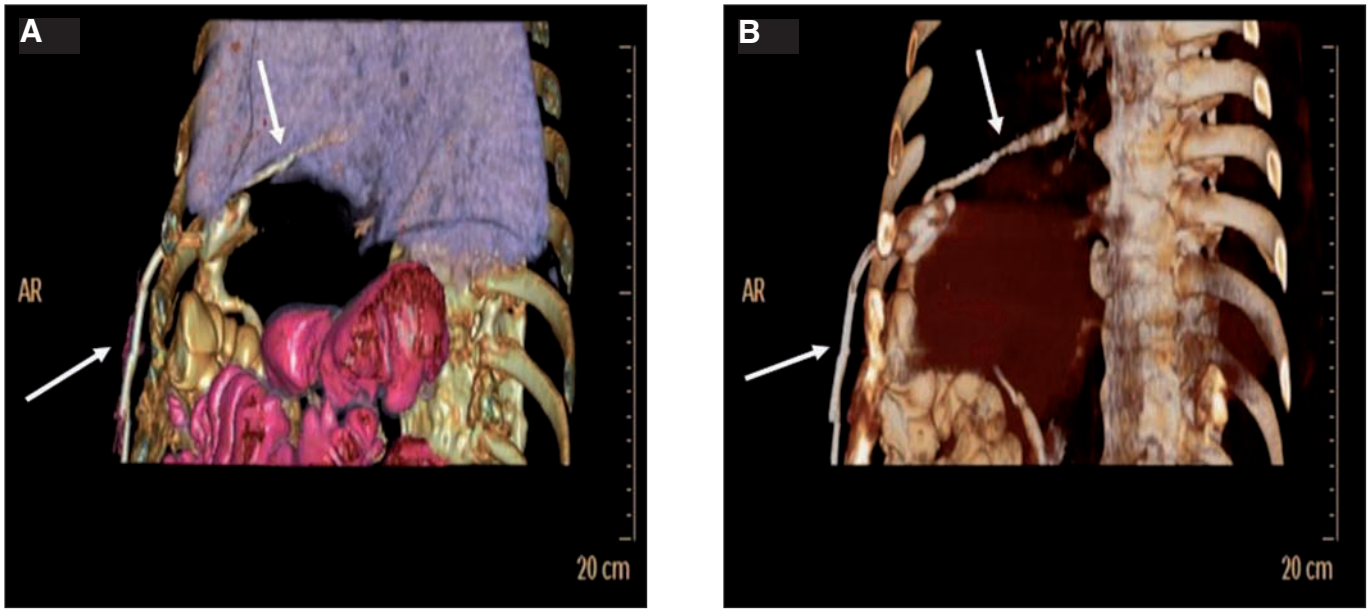

Fig. 1 A and B. CT scan 3-D reconstruction showing a percutaneous biliary drainage (lower arrows) which leads to identify a fistulous bronchobiliary pathway after contrast administration (upper arrows).

DISCUSSION

Biliobronchial fistula is an infrequent entity, often linked to hydatidosis or biliary obstruction (1), as a result of a local inflammatory process with abscessification and rupture towards lung and bronchi. It can lead to significative complications, including chemical and bacterial pneumonitis, or mediastinitis, with morbimortality up to 12.2% (2).

Biliary sputum –bilioptysis– is pathognomonic (3). CT scan offers a first subphrenic and basal lung assessment. Endoscopic retrograde or percutaneous cholangiography display the biliary anatomy. Contrast-enhanced magnetic resonance adds functional information (4).

Therapy is based on endoscopic decompression with stent o percutaneous puncture. If these options are not feasible, an open surgical desobstruction is indicated, together with abscess evacuation and excision of the fistulous tract (5).

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