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Accepted Article

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Cholecystocutaneous fistula

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Dear Editor,

We present the case of an 83-year-old female with diabetes and chronic renal disease who was admitted to hospital three months previously due to cholangitis secondary to choledocholithiasis. She underwent an endoscopic retrograde cholangiopancreatography (ERCP) for stone removal as well as a papillotomy and was subsequently admitted due to abdominal pain and fever. A mass effect was perceived in the right upper quadrant with pastiness, signs of local infection and a fluctuating area that spontaneously drained purulent matter. The culture was positive for *Pseudomonas aeruginosa* and *Morganella morganii*. Thus, a course of imipenem was started. Abdominal computed tomography (CT) identified extravascular gallstones within the adjacent abdominal wall and in the subcutaneous cellular tissue. Furthermore, a phlegmonous area 8 x 2 cm in size was found in the subcutaneous tissue, with some small bubbles engulfing extravasated stones (Fig. 1). The patient underwent a partial cholecystectomy and drainage and a final diagnosis of acute gangrenous cholecystitis with skin fistulization was made.

Discussion

Biliary fistulae are classified as internal or external. With regard to internal fistulae, 75% communicate with the duodenum, 15% with the colon and 10% with the jejunum, stomach or bronchia. External fistulae communicate with any area in the anterior aspect of the trunk and are extremely rare, with fewer than 100 cases reported in the medical literature (1,4).

Spontaneous external biliary or cholecystocutaneous fistula result from gallbladder rupture; a fistulous tract develops in the skin without prior biliary surgery or trauma (5). It is an uncommon complication of cholelithiasis as it is usually diagnosed and managed early (1,3).

Major causes include gallbladder neoplasms and anatomical abnormalities or surgical-related changes. However, most are associated with vesicular lithiasis. This increases intraluminal pressure and compromises parietal circulation and potentially leads to ischemia, necrosis, perforation, bacterial translocation and ultimately peritoneal abscesses or abscesses that communicate with the abdominal wall. Thus, resulting in external fistulae (1,2).

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Fig. 1. Extravesicular gallstones within the adjacent abdominal wall and the subcutaneous cellular tissue; a phlegmonous area in the subcutaneous tissue, with some small bubbles that engulf extravasated stones.

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