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DOI: 10.17235/reed.2021.7989/2021
Link: PubMed (Epub ahead of print)

Please cite this article as:
Pérez Moyano Sara, Morillo Blanco Lorena, Guilarte López-Mañas Julio. Remaining cist syndrome in a cholecystectomidez patient confirmed by conlangiography. Rev Esp Enferm Dig 2021. doi: 10.17235/reed.2021.7989/2021.

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CC 7989

Cystic duct remnant syndrome in a cholecystectomized patient, confirmed by cholangiography

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Keywords: Post-cholecystectomy syndrome. Cystic stump syndrome. Biliary dyskinesia.

Conflicts of interest: the authors declare no conflicts of interest.

Dear Editor,

Wereport the case of a 59-year-old male with cholelithiasis, choledocholithiasis, and biliary obstruction due to enolic chronic pancreatitis. He was treated 7 years previously with cholecystectomy, ERCP, and a fully-coated biliary metal stent for 6 months. He attended the emergency department due to progressive jaundice and abdominal pain. An abdominal ultrasound showed a non-distended gallbladder with a 12-mm lithiasis and biliary mud with dilatation of the intrahepatic (IBD) and extrahepatic (EBD) bile duct. An ERCP was performed due to the inconsistency between the findings and the history. The cholangiography corroborated the dilatation of the IBD and proximal EBD with lithiasic content and stricture of the intrapancreatic common bile duct. A low-insertion dilated cystic duct was filled, whose proximal portion increased in volume, acquiring the appearance of a neobladder (cystic duct remnant syndrome). A plastic biliary stent was inserted after the duct was cleaned.

DISCUSSION

In all, 5-15 % of patients undergoing cholecystectomy present symptoms similar to those described above, referred to as post-cholecystectomy syndrome. The causes are classified according to the appearance of symptoms, as early (cystic duct remnant syndrome or CDRS, alteration of the bile duct or bile leakage) or late (alteration of the biliary structure, residual lithiasis in the cystic duct remnant or its inflammation, and papillary stenosis, etc.). CDRS has a prevalence of less than 2.5 % and is defined as a residual cystic duct remnant of more than 1 centimeter in length. It can cause symptoms if there is lithiasis within it, due to distension of the remnant, which may be accompanied by laboratory alterations. This duct is detected by imaging tests, of which cholangiography is the method of choice. Treatment may comprise extracorporeal lithotripsy or be performed directly via cholangioscopy, although surgical treatment via laparoscopy is the treatment of choice. Our case is currently awaiting surgery and re-evaluation of the intrapancreatic choledochal stricture in the event that a new coated metal stent is required.

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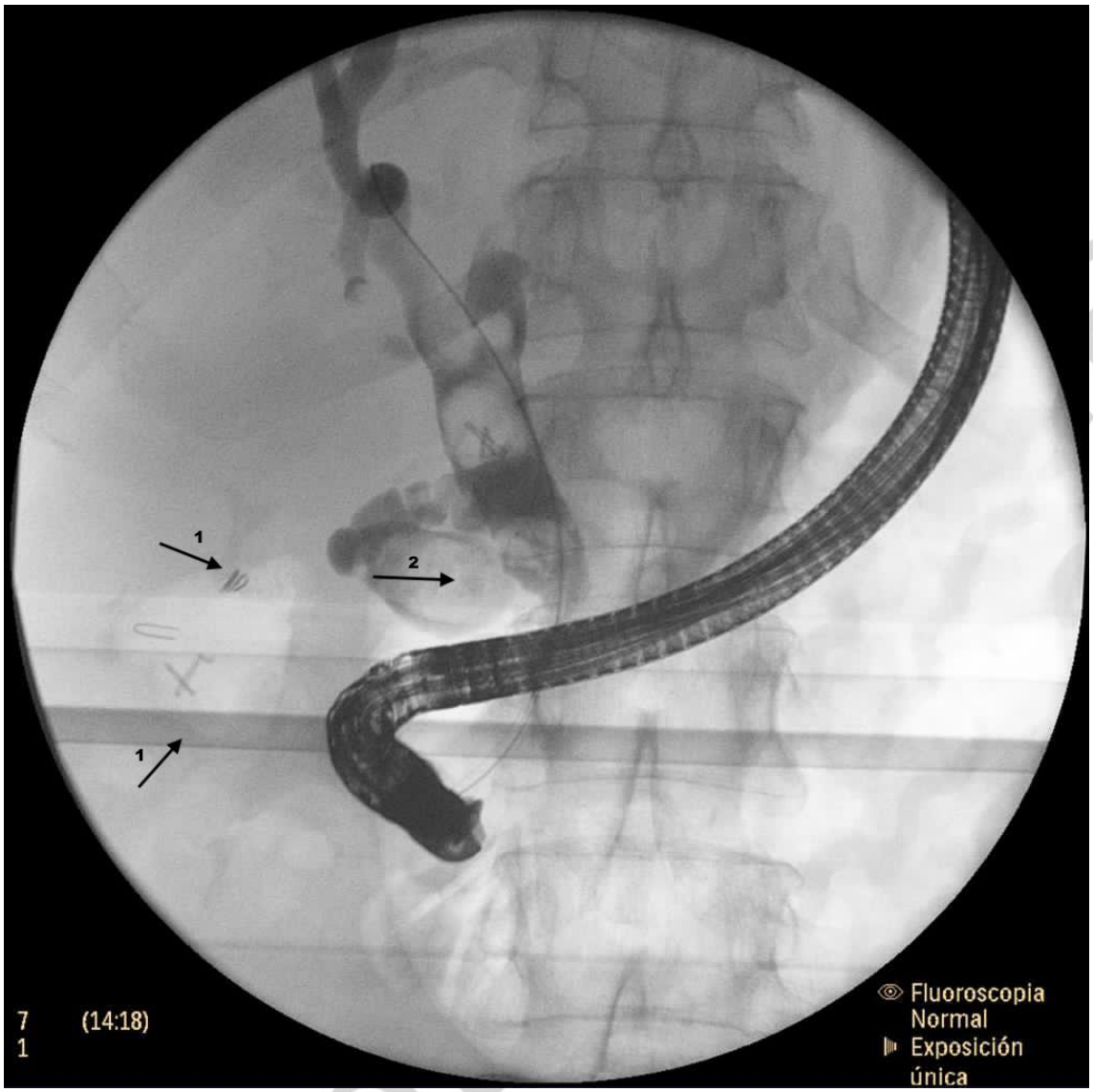

Fig. 1. Cholangiography. 1. Remnant cystic walls ("neobladder"). 2. Remanent cystic duct filling with lithiasis inside.