Dear Editor,

A 78-year old male was admitted due to oral intolerance with postprandial vomiting and weight loss. A gastroscopy was performed which showed esophageal candidiasis and duodenal stenosis. A biopsy was performed with normal histology. Treatment with proton pump inhibitors was prescribed and computerized tomography was performed, which showed thickening of the pyloric-duodenal area and cholelithiasis, without evidence of ectopic stones. Endoscopic ultrasonography (EUS) was performed, showing a fourth layer thickening, in close contact with the gallbladder, full of stones but with normal walls. A wall thickening EUS-PAAF was performed and cytology only showed normal muscular tissue. However, EUS also showed a fistulous tract between gallbladder and antro-pyloric area (Fig. 1), which was interpreted as cholecystogastric fistula and the patient was evaluated by surgeons. During surgery, a petrous antro-pyloric thickening was identified, without transmural involvement and no tumor exteriorization, but with a retentionist dilated stomach. The gallbladder was distended without inflammatory signs. At the level of lesser omentum and from the gallbladder neck, an apparent connection to the pyloric area
was identified. Roux -en-Y diversion was performed, confirming the presence of a fistula between the gallbladder neck and the pyloric region. The patient progressed favorably after surgical intervention.

Cholecystogastric fistulas have been described since 1968 (1), with an incidence of 3-5 % in patients with cholelithiasis (2). The fistula usually occurs in the duodenum and to a lesser extent in the gastric chamber (3). Bouveret syndrome is gastric obstruction secondary to the impact of a stone in the duodenal bulb; in our case, it is striking that no pneumobilia or any stone impacted outside the gallbladder was identified, so we assumed that it had already been expelled spontaneously. The classic radiological findings of Bouveret syndrome form the Rigler triad: intestinal obstruction, pneumobilia and ectopic stone (4). In our case, it was the endoscopic ultrasound that gave us the definitive diagnostic image and we have not found a similar case in the literature. Cases of endoscopic treatment have been described when an impacted stone is identified (5), but in our case, given its absence and the patient's deterioration, surgery was chosen, with good subsequent evolution.

References

Fig. 1. Fistulous tract between gallbladder and antrum visualized by endoscopic ultrasonography.