

Development of bile duct bezoars following cholecystectomy caused by choledochocolonic fistula formation

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A 55-year-old female patient presented with a history of recurrent episodes of cholangitis during the last 6 months. She underwent open cholecystectomy five years ago for symptomatic cholelithiasis. Laboratory data on admission showed elevated alkaline phosphatase 1217 IU/L (nl 64–306); total bilirubin 0.8 mg/dL (nl 0.2–1.1); SGOT 78 U/L (nl 5–40); and SGPT 85 U/L (nl 5–40). She was evaluated with magnetic resonance cholangiopancreatography (MRCP), which revealed dense sludge occupying the entire common bile duct (CBD) up to the common



Figure 1 (MRCP) Demonstration of common bile duct sludge with choledochocolonic fistula

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Figure 2 a (Surgical Photographs) Demonstration of common bile duct exploration and removal of bezoar, **b** (Surgical photographs) Demonstration of choledochocolonic fistula, **c** (Obstructing materials) Bezoar material in the shape of a common bile duct cast removed from the dilated common bile duct by surgery

hepatic duct [Fig. 1]. There was a fistulous tract between the CBD and transverse colon which necessitated surgical removal of the material from CBD, dismantling of fistula and closure of colonic rent [Fig. 2a,b,c]. Choledochocolonic fistula caused concretion of fecal matter in the CBD that accumulated and coalesced to form a bezoar. A histological assessment of the object revealed fibrinoid material with some cellular debris.

To conclude, bezoar formation within the bile duct should be taken into consideration as a differential diagnosis in cases

of intermittent obstructive jaundice and associated choledochenteric fistula.

Reference

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