REFERENCES

Cholecyst-Thoracic Fistula*

A Rare Complication of Lithiasic Cholecystitis

Miguel Angel Corral Sánchez, M.D.; Ramón Gómez Sanz, M.D.; Arnaldo Alvarado Astudillo, M.D.; Pedro Rico Selas, M.D.; and Enrique Moreno González M.D.

A 64-year-old male patient was studied for repeated right basal pneumonia of long duration. A computed tomography scan showed a cholecystitis of concealed evolution. Surgery revealed fistulation toward the thorax, with the passage of multiple calculi of a biliary origin to the chest cavity. We report the first described case to our knowledge of cholecyst-thoracic fistula secondary to cholecystitis of long evolution.

(Chest 1994; 106:1303-04)

A biliary origin for a right basal pneumonia is rare, and after reviewing the literature, we have not come across any cases of cholecyst-thoracic fistula with passage of multiple biliary calculi toward the thorax as a complication of cholecystitis. There do exist two cases of biliary calculi migration toward the thorax, 6 months and 6 years after a laparoscopic cholecystectomy and a laparotomy.

*From the Department of Surgery, 12 de Octubre Hospital, University of Madrid, Spain.

FIGURE 1. Chest radiograph showing right basal infiltrate.

cholecystectomy, respectively,1,2 subsequent to accidental puncture of the gallbladder during the surgery.

We studied a patient who presented to the hospital with a clinical pattern of right basal pneumonia of torpid, insidious evolution, initially diagnosed as a middle lobe bronchus syndrome, when in fact it was a cholecystitis with cholecyst-thoracic fistula complications.

CASE REPORT

The patient was a 64-year old man, diagnosed 5 years ago as having lithiasic cholecystitis and requiring hospitalization. He was discharged 15 days after a satisfactory clinical evolution with conservative medical treatment because he rejected surgery. In September 1991, the patient visited the emergency room coughing up abundant purulent expectoration, having a fever of 39°C, and sharp pain in the right hemithorax. We found no accompanying digestive symptoms. The x-ray film of the thorax (Fig 1) revealed right basal pneumonia. Antibiotic treatment was initiated and the patient’s clinical condition improved, although the right basal pneumonia persisted in the radiologic images. We referred the patient to the Pneumonic Service for study. Fiberoptic bronchoscopy revealed signs of bronchitis in the right bronchial system and discrete flattening of the middle lobe bronchus entrance. Bronchial biopsy showed acute necrotizing inflammation with no evidence of malignancy. Escherichia coli and Proteus mirabilis grew in the percutaneous transtracheal tap. As these germs are typical of the digestive apparatus, and in light of the previous lithiasic cholecystitis, an abdominal origin was suspected for the pneumonia. Thoraciacolobdominal computed tomography scan (Fig 2) detected a right subphrenic collection continuing downward, with thickened walls and internal calculi in the gallbladder. The collection appeared to extend beyond the diaphragm.

Complicated cholecystitis was diagnosed and surgery indicated. Right subcostal adhesions were observed via laparotomy from the gallbladder area and liver to the diaphragm, hindering entry into the abdomen. Gallbladder adhesion to the diaphragm was observed, as was a perforation of the gallbladder fundus in the form of a 5-cm orifice through the right diaphragm and toward the thorax over the liver cupula. The orifice led to an anfractuous cavity of some 10X10 cm, from which multiple gallstones and pus were extracted. Exploration of the cavity verified its location over the diaphragm. Given the cavity’s complete isolation due to the inflammatory reaction, it was decided to drain via the abdominal cavity and adopt measures in anticipation of possible pulmonary lesions. The rest of the gallbladder was adhered firmly to the liver hilus. Cholecystectomy was performed. Cholangiography during the operation produced no sig-
significant findings. Two drains were left—subhepatic and subphrenic, the latter in the thoracic cavity. Ceftriaxone and clindamycin treatment was administered during 5 postoperative days. The patient recovered favorably and without complications and was, therefore, discharged on the eighth day after surgery.

DISCUSSION

Acute cholecystitis is the most frequent complication of cholelithiasis. Currently, early diagnosis with echography and urgent or elective surgery in patients with cholecystitis or cholecystitis allow avoidance of further complications. Our patient developed cholecyst-thoracic fistula after a longstanding cholecystitis.

Gallbladder perforations with passage of calculi to the duodenum, colon, and peritoneum have been reported previously. On rare occasions, subphrenic abscess may manifest itself clinically in the form of a respiratory infection pattern, either pneumonia or pleural empyema, even with pericarditis, pericardial effusion, and cardiac tamponade. Thoracobiliary fistula has been described in patients with liver hydatidosis.

We have not found in the literature any cases of recurrent pneumonia secondary to cholecystitis. Our patient presented a pattern of right basal pneumonia with an evolution of 1 year, ruling out primary, tumoral, infectious or other suchlike pulmonary pathologic conditions. During the disease’s evolution, the positive finding in one of the transtracheal taps of typical digestive system germs led to suspicion of an underlying abdominal pathologic condition. The computed tomography scan could not establish the cholecyst-thoracic fistula, but it showed severe cholecystitis as a possible cause of the definitively repeated right basal pneumonia.

We do not know the exact etiopathogenic mechanisms in the development of this cholecyst-thoracic fistula. However, we suspect two possible mechanisms: (1) an extrhepatic gallbladder with free fundus and possible contact with the diaphragm, and (2) the infection of the gallbladder (empyema) makes adhesions and progressive perforation logical evolutive mechanisms.

We stress the need not to defer surgery in patients with complicated cholelithiasis and in those with the possible thoracic complications—effusion, empyema, pneumonia—of advanced cholecystitis.

REFERENCES


Sarcoid Reactions in Cystic Duct Carcinoma*

Marc Klein, M.D.; Pierre Kaminsky, M.D.; Joelle Deibener, M.D.; Marie-Pierre Cocciale, M.D.; and Michel Duc, M.D.

A diagnosis of sarcoidosis was evoked in a 61-year-old man on clinical and histologic bases. Nevertheless, a bile duct carcinoma was disclosed in association with the discovery of generalized sarcoid-like granulomas. This is only the third time that such an association has been described. HLA-B8, DR3, and DRw52 antigens were found, suggesting that altered immunologic mechanisms could play a role in the pathogenesis of this sarcoid-like reaction.

(Chest 1994; 106:1304-05)

Key words: carcinoma; concomitant disease; cystic duct; sarcoid reaction

Bilateral hilar adenopathy with diffuse noncaseating epithelioid-cell granulomas is highly suggestive of sarcoidosis. Nevertheless, granulomatous reactions can occur in other disorders, such as malignant tumors. We report a case of cholangiocarcinoma associated with a systemic sarcoid reaction that mimics pulmonary sarcoidosis.

The presence of HLA-B8 and DR3 antigens found in this case report could support the hypothesis that altered immunologic mechanisms may play an important role in the pathogenesis of this sarcoid-like reaction. High levels of tumor necrosis factor and interleukin 2 were found and could account for the development of such granulomas.

CASE REPORT

A 61-year-old man experienced fever, a 10-kg weight loss during the last 6 months, night sweats, weakness, and abdominal pain. Gastrointestinal investigations, including upper and lower endoscopy, abdominal ultrasound, and computed tomography (CT scan) were normal except for slight intrahaepatic biliary duct dilatation. Chest radiograph (Fig 1) and CT scan revealed bilat-

*From the Service de Médecine J, Centre Hospitalier Universitaire de Nancy, Hôpitaux de Brabois, Vandoeuvre-les Nancy, France.