


Case Report

Inguinal abscess after gallstone spillage during lap cholecystectomy: An unusual presentation

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Abstract

62 year old lady was presented with small painful swelling in inguinal regional. On examination, there was 2x2 cm swelling in the right inguinal region with overlying skin red in color. Swelling was tender to touch with raised local temperature, firm in consistency, non-reducible and non-compressible with no transmitted pulsations. FNAC report was showing only inflammatory cells. Ultrasound was normal for abdomen but it showed presence of foreign body deep inside the sinus tract. Sinus tract was excised along with foreign body. Gallstone abscess are although rare to develop but they are seen occasionally. As are seen in our case lap cholecystectomy was performed 9 months ago and a single 7 mm stone was extracted from abscess in inguinal region.

Key words

Post-cholecystectomy, Inguinal abscess, Stone.

Introduction

In 1882, Carl Langenbuch, a noted German surgeon, performed first successful cholecystectomy through a T shaped incision [1]. After that a lot of alterations occurred in incision but procedure remains same. First lap cholecystectomy was performed in 1987 and since then it is considered to be a gold standard method for gallstone management. During

removal of gallbladder, stone spillage can occur which is higher in lap cholecystectomy than open cholecystectomy [2]. In lap cholecystectomy gallstone spillage rate ranges from 5-40% [3]. When in abdominal cavity these stones, if left inadvertently, can migrate to various region of abdomen and can present as gallstone abscess. We report an unusual case of 62 year female that was operated upon for cholelithiasis and

presented with inguinal abscess eighth months after operation.

Case report

Presentation of case

62 year old lady was presented in August 2018 with small painful swelling in inguinal regional. On examination, there was 2x2 cm swelling in the right inguinal region with overlying skin red in color. Swelling was tender to touch with raised local temperature, firm in consistency, non-reducible and non-compressible with no transmitted pulsations. Cough impulse was negative. She was afebrile and all her parameters were normal.

Clinical diagnosis

With above findings a clinical diagnosis of inguinal lymphadenitis was made. For this, drainage area of right inguinal lymph nodes was thoroughly examined. Her right lower limb, lower part of abdomen and back, perineal area and perianal area was examined and was found to be exactly normal.

Differential diagnosis

With above findings, following differential diagnosis was made

- Right inguinal lymphadenitis
- Obstructed hernia
- Local abscess

Pathological discussion

Patient was then put on antibiotics and was advised to undergo FNAC test. FNAC report was showing only inflammatory cells therefore patient was advised to come after one week on completion of antibiotic course. When patient came after one week she had small sinus opening at the site of swelling with serosanguinous discharge. Pus culture and sensitivity was sent and advised to come with report of pus culture and sensitivity after one week. Report showed staf aureaus sensitive to amoxyclave. Therefore patient was put on amoxyclave and was advised to come after one week. When patient came after one week she says there is no improvement and

discharge is same. She was advised to continue with same antibiotics and was called after one week. As she came after one week, discharge was not decreased. Then she was advised sonography of local region as well as abdominal region. Ultrasound was normal for abdomen but it showed presence of foreign body deep inside the sinus tract (**Figure - 1**). So patient was immediately taken in the minor operation theatre and sinus tract was excised along with foreign body and wound was then closed with two zero silk stitch. On close examination the foreign body which we had extracted seems to be a stone (**Figure - 2**) and therefore it was sent for chemical analysis in path lab. Report from path lab described it to be made of cholesterol (100%) only.

Figure – 1: Ultrasonography.

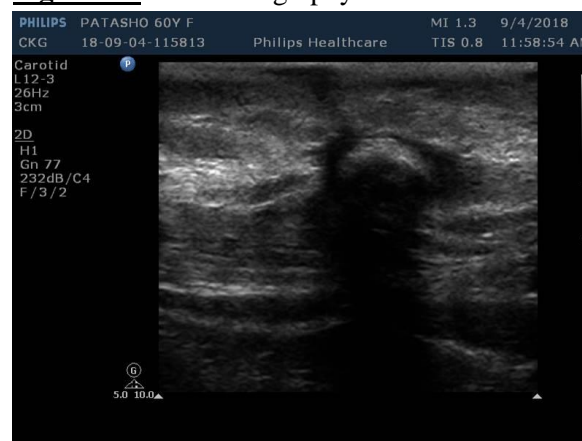
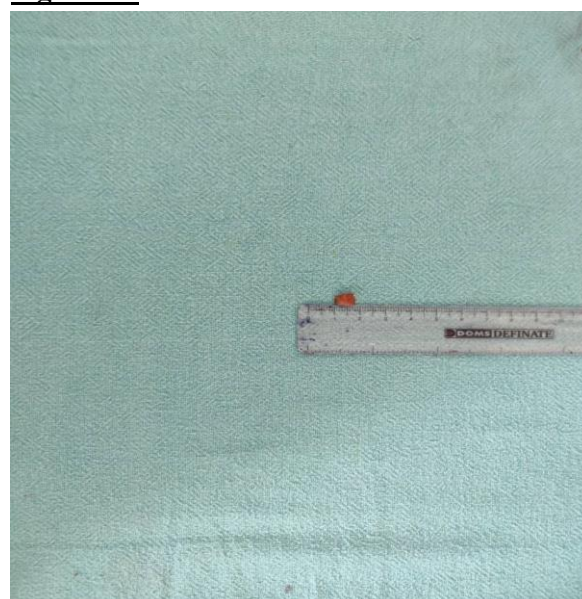


Figure – 2: Stone.



Discussion of management

After we got the chemical analysis report of stone whole case was reviewed again. On reviewing the case it was found that she had undergone lap cholecystectomy in December 2017 for chronic calculus cholecystitis. Ongoing through operative findings it was found that her gallbladder had dense adhesions with omentum and duodenum and during dissection and removal of gallbladder from liver bed, the gall bladder was perforated and stones were spilled in the morrison pouch. However after removal of gall bladder all stones were removed from the morrison pouch and abdominal cavity. Gall bladder fossa, superior surface of liver and perineal cavity was thoroughly washed with normal saline with the help of suction and irrigation before closing the port sites. She remained absolutely normal afterwards and was therefore discharged after three days and was advised to come after five days for stitch removal. Her stitches were removed on eighth day and then she was advised to come after fifteen days to collect her histopathology report of gall bladder. She came after 15 days and collected her histopathology report which showed changes of chronic cholecystitis. She had no complaint at that time and her wound was normal. After that she came in August 2018 when she presented in my OPD with small 2x2cm painful swelling in inguinal region.

Lap cholecystectomy is the gold standard treatment for gallstones. During lap cholecystectomy there is higher rate of spillage of gallstones as compared to open cholecystectomy because of greater chances of gall bladder perforation. Secondly these spilled gallstones can be easily identified and removed in open cholecystectomy as compared to lap cholecystectomy [4]. The spilled gallstones should be removed very carefully as if the stones are left in abdominal cavity these can cause various complications months or years after cholecystectomy [5, 6]. Most common complications due to stone spillage during cholecystectomy are abdominal wall abscess and intra-abdominal abscess [2] and rarely even

paraspinal abscess [7]. Other complications due to left over stones are obstruction, fistula, intestinal perforation and pleural empyema. Management of abscess because of spilled gallstones is drainage of abscess and manual removal of stones along with antibiotics. The sequence of events that can help with removal of spilled gallstones is described by Papasavas, et al. [8].

Final diagnosis

Gallstone abscess are although rare to develop but they are seen occasionally. As are seen in our case lap cholecystectomy was performed 9 months ago and a single 7 mm stone was extracted from abscess in inguinal region. This stone might have been left in the abdominal cavity during surgery and later on it penetrates through the anterior abdominal wall to present as an inguinal abscess. This case signifies that even single 7 mm left over stone can produce abscess and therefore each and every spilled stone should be retrived carefully during surgery.

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