Scholars Journal of Medical Case Reports **ISSN 2347-6559 (Online)**
Sch J Med Case Rep 2015; 3(9A):847-848 **ISSN 2347-9507 (Print)**

(An International Publisher for Academic and Scientific Resources) DOI: 10.36347/sjmcr.2015.v03i09.016

Gallbladder Perforation in a Case of Acalculous Cholecystitis

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Abstract: Gall bladder perforation is a rare complication of cholecystitis. A definitive diagnosis is uncommon before surgery and the morbidity and mortality associated with this condition are high. We present a case of acute cholecystitis with gall bladder perforation.
Keywords: Gallbladder perforation, cholecystitis.

INTRODUCTION

Gall bladder perforation is a rare but life-threatening complication of acute cholecystitis [1]. Two percent of patients undergoing cholecystectomy are found to have perforation of the gall bladder. It occurs in 10% of patients who are being treated conservatively [2]. Most studies in which the patients are generally aged 60 or more. Studies reported a mortality rate of 42%; others have reported mortality to be between 12 and 16% [3, 4, 5]. Due to the high mortality that can be caused by a delay in the correct diagnosis and following adequate surgical treatment, gallbladder perforation represents a special diagnostic and surgical challenge [6]. Most cases can only be diagnosed during surgery [7, 8, 9].

CASE REPORT

A 55 year old man presented with a two day history of acute severe epigastric pain. Examination showed board-like rigidity in the upper abdomen with considerable tenderness. He had mild fever but no other signs. Total count was raised. No free gas was seen under the diaphragm on the chest X- ray but shows pleural effusion on right side. Erect X-ray abdomen was normal.

Ultrasound abdomen revealed acalculous cholecystitis with suspicious rent in fundic region. CT scan revealed features of sub acute gallbladder perforation with pericholecystic abcess formation. A clinical diagnosis of peritonitis was made. The patient was brought to theatre and an upper midline incision was made. On entering the peritoneal cavity, About 200 ml of pus mixed with bile was drained and a gangrenous gall bladder was seen with omentum stuck to its fundus where it was perforated.

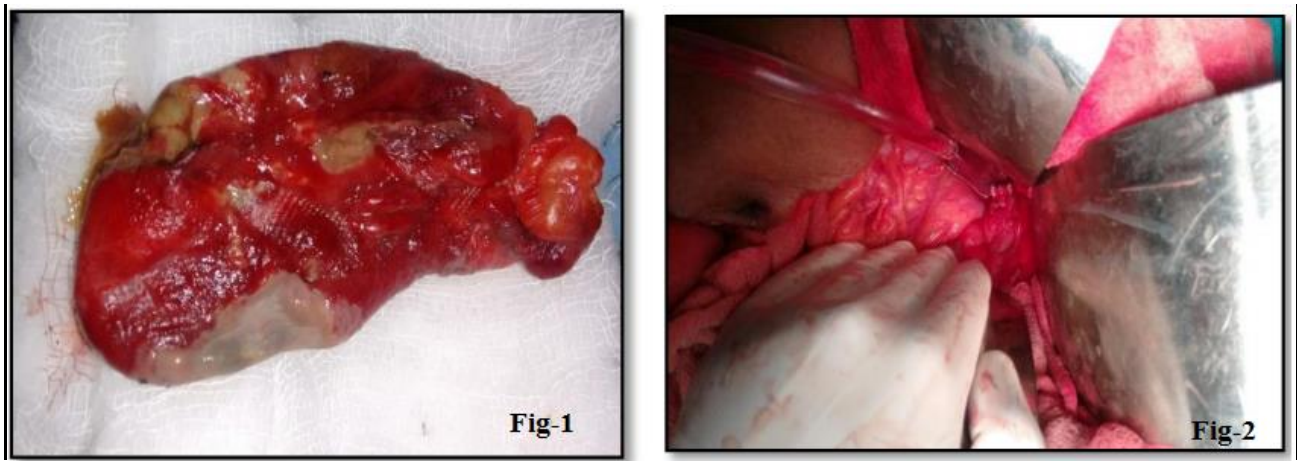

Fig 1:Specimen of gangrenous perforated gallbladder & Fig-2: Ligation of cystic duct & Cystic artery

No stones were found in the gall bladder but there was sludge present. A cholecystectomy was performed and right sub hepatic drain was kept. Post operatively patient's condition improved rapidly. Drain

was removed on 3 rd post operative day and sutures were removed on 8th day. The patient's recovery was uneventful and was discharged on the 10th postoperative day. He is on regular follow up without any complaints.

DISCUSSION

Glenn reported a mortality rate of 42%. Studies have reported mortality to be between 12 and 16% [3, 4, 5]. But our patient survived. This can be attributed to the fact that our patient was operated immediately. Our patient had acute presentation with no previous symptoms associated with disorders of the hepatobiliary system. Liver function tests were normal. The perforation was of type II, which is the most common type.

Treatment of choice for acute gall bladder disease is early surgery. Studies have advocated early and urgent cholecystectomy for acute gall bladder disease [10, 11]. They reported the risk of perforation to be between 3 and 12% in patients treated conservatively for acute cholecystitis. They also showed that the mortality and morbidity for emergency cholecystectomies compared favourably with those for elective surgery and concluded that in well selected patients, emergency cholecystectomy for acute cholecystitis should be advocated as a safe procedure. Gall bladder perforation is an uncommon but life threatening complication of acute cholecystitis. Early diagnosis is not easy. If diagnosed early, requires emergency surgery.

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