



CASE REPORT

Gastrointestinal bleeding of obscured origin due to cystic artery pseudoaneurysm



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Summary Cystic artery pseudoaneurysm is a rare condition, which usually arises from the complication of gallstone disease. Patients may present with Quinke's triad (epigastric pain, obstructive jaundice, and gastrointestinal bleeding). The results can be fatal if present with a ruptured pseudoaneurysm. We report a patient who presented with upper gastrointestinal bleeding, and later diagnosis was confirmed with a computer tomography scan of the abdomen and a three-vessel angiogram. Endovascular intervention was attempted. Although it failed, the patient was eventually cured with an open cholecystectomy.

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1. Introduction

Common presentations of cystic artery pseudoaneurysm vary from epigastric pain, obstructive jaundice, gastrointestinal bleeding, and free intraperitoneal rupture. Classically, Quinke's triad was only found in around 56% of patients.¹ Its rarity resulted in diagnostic difficulty, and mainly case reports were reported.

Management of gastrointestinal bleeding of obscured origin requires a combination of upper endoscopy and colonoscopy. However, this fails to reveal the source of bleeding in approximately 5% of patients with gastrointestinal hemorrhage.² The use of further diagnostic investigation tools depends on the stability of the patient, which include a computer tomographic (CT) scan of the abdomen, a three-vessel angiogram, red blood cell nuclear scan, small bowel enteroscopy, and operative intervention.

We present a patient who initially presented with biliary colic, and subsequently developed a complication of cystic artery pseudoaneurysm. This illustrates the management approach and timely intervention used to prevent potential complications.

Conflicts of interest: The authors disclose no conflicts of interest.

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2. Case report

A 64-year-old man presented with epigastric pain for 6 months. He was a nonsmoker and had no complaints of passing tarry stools. On physical examination, the patient was not pale and he had mild jaundice. Liver function tests showed that the serum bilirubin level was 70 $\mu\text{mol/L}$ and the alkaline phosphatase level was 224 U/L. Ultrasound of the abdomen was performed, which showed gallstones. The common bile duct (CBD) was mildly dilated with a small stone at the lower end of the CBD. Endoscopic retrograde cholangiopancreatography (ERCP) was performed on the patient which showed sludge only at the lower end of CBD. The contrast filled up the gallbladder via the cystic duct. Filling defects were found inside the gallbladder. Papillotomy was performed and an Fr 7 pigtail stent was deployed (Fig. 1). His liver function returned to normal and the patient was scheduled to receive an elective laparoscopic cholecystectomy. However, the patient complained of passing melena 10 days after the ERCP. Upper endoscopy was performed which did not reveal any bleeding from the stomach and the duodenum. The papillotomy site was clean. A colonoscopy was performed which was also normal. An urgent CT scan of the abdomen was performed (Figs. 2 and 3) which showed a lesion in the gallbladder. The noncontrast CT of the abdomen (Fig. 2) showed that there was a hypodense lesion at the gallbladder neck. There was a rim of hyperdense fluid inside the gallbladder mucosa compatible with acute hemorrhage of the gallbladder mucosa. The contrast-enhanced phase of the CT abdomen (Fig. 3) showed contrast enhancement of the gallbladder neck lesion. The overall clinical picture was compatible with cystic artery pseudoaneurysm due to complication of gallstone disease, i.e., gallstone erosion. The differential diagnosis included a benign or malignant lesion of the gallbladder leading to acute bleeding.



Figure 1 ERCP showing a normal size CBD with filling defects inside gallbladder, compatible with stones.

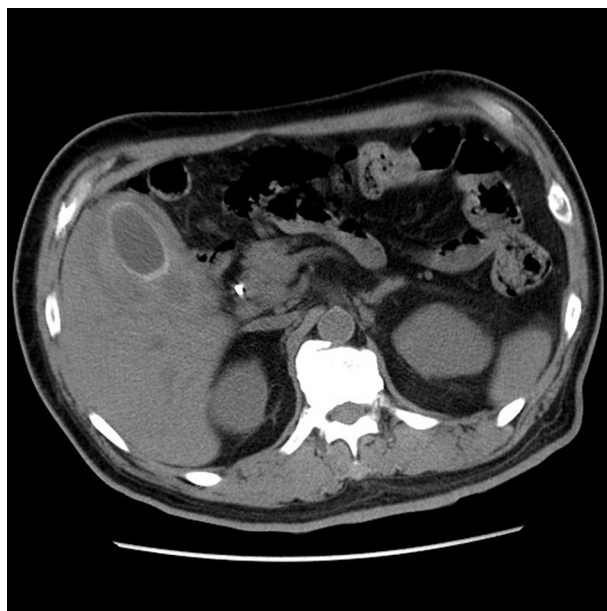


Figure 2 A noncontrast CT of the abdomen showing a hypodense lesion at the gallbladder neck.

In order to confirm the diagnosis, an urgent angiogram was performed. An angiogram including the cannulation of the celiac artery, superior mesenteric artery (SMA) and inferior mesenteric artery (IMA) was performed. Because cystic artery pseudoaneurysm was suspected, a celiac artery angiogram was performed first. Fig. 4 (Movie A) shows a celiac artery angiogram with opacification of the hepatic artery. There was no contrast extravasation in the hepatic artery and cystic artery territory. Fig. 5 (Movie B) shows an SMA angiogram. In this angiogram, there was a replaced



Figure 3 The contrast-enhanced phase of the CT scan of the abdomen, showing contrast enhancement of the gallbladder neck lesion.

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