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LETTERS TO THE EDITOR
EDİTÖRE MEKTUP
Surgical challenge in cholecystectomy: Xanthogranulomatous cholecystitis

Kolesistektomi cerrahisinde zorluk: Xanthogranulomatöz kolesistit

To the Editor

Xanthogranulomatous cholecystitis (XGC) is a rare, benign destructive, chronic inflammatory disease, which is difficult to distinguish from gallbladder cancer (1, 2). We herein present two cases of XGC operated on without any complication.

Two patients admitted to the hospital with right upper quadrant pain, fever and chills. Both patients had a history of multiple episodes of cholecystitis previously. Physical examinations revealed signs of cholecystitis. Laboratory tests were within normal ranges.

Abdominal ultrasound revealed gallbladder wall thickening and gallstones in both patients. Computerized tomography (CT) did not provide any additional information.

Conventional cholecystectomy was preferred for the first patient because of the foresight of difficulty in cholecystectomy. Adhesions to the neighboring structures were separated by sharp dissection; however, dissection from the liver was not possible. Total cholecystectomy and excision of the adjacent xanthogranulomatous tissue was performed.

We operated on the second patient laparoscopically. Dissection was easy in the Calot triangle, but difficult in the corpus and fundus area because of the dense adhesions. The gallbladder bed of the liver was excised with electrocautery. The patient developed some hemorrhage postoperatively, but no transfusion of blood compounds was needed.

Both of the patients were discharged in good condition on the 7th day following surgery. They have been followed up uneventfully for 17 months and 6 months, respectively.

Permanent section evaluations revealed a diagnosis of XGC affecting the whole gallbladder in the first (Figure 1) and a focal area in the second patient. There was no evidence of malignancy in either of the patients.

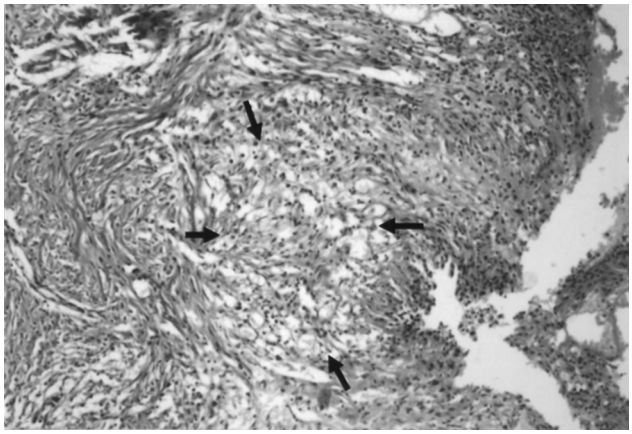

Figure 1. Histopathologic photography of case 1: mononuclear cell infiltration and foamy histiocyte deposits within the gallbladder wall. Area of foamy histiocytes is shown with thick arrows (Hematoxylin and Eosin, X100)

Xanthogranulomatosis is defined as the presence of chronic inflammatory cells, including lymphocytes, plasma cells and foamy, lipid-laden macrophages (3, 4). The mechanism leading to this condition is unclear (1, 5, 6).

Symptoms often begin with an episode of acute cholecystitis (1). A high incidence of gallstones has

Address for correspondence: Kemal KARAKAYA
Department of General Surgery, Zonguldak Karaelmas University, Faculty of Medicine, Kozlu, Zonguldak, Turkey
Phone • Fax: +90 372 266 05 09
E-mail: knkarakaya@gmail.com

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been reported in patients with XGC. XGC is characterized macroscopically by tumor-like mass of the gallbladder (3, 5). It can simulate gallbladder cancer (1, 3-7). Frozen section has been recommended to rule out malignancy (2, 7). The diagnosis is usually possible only after pathological examination. We did not perform frozen section evaluation in our cases due to technical unavailability in the first and consideration of chronic cholecystitis in the second case.

The best management of XGC is cholecystectomy and excision of adjacent xanthogranulomatous tissue. Conversion of laparoscopic cholecystectomy is essential to avoid complications when in doubt. Intraoperative frozen section examination may be useful to rule out gallbladder carcinoma.

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Kemal KARAKAYA, Öge TAŞÇILAR, Güldeniz KARADENİZ ÇAKMAK, Bülent UÇAN, Ali Uğur EMRE, Oktay İRKÖRÜCÜ, Mustafa CÖMERT

Department of General Surgery, Zonguldak Karaelmas University, Faculty of Medicine, Zonguldak