

LETTERS TO THE EDITOR

EDİTÖRE MEKTUP

A giant gallstone

Dev safra kesesi taşı

To the Editor

Gallstone disease remains one of the most common medical problems leading to surgical intervention. Some patients may remain asymptomatic, while some progress to a symptomatic stage (1).

A 70-year-old man admitted to the hospital with complaints of abdominal pain in the right upper quadrant. According to his history, he had experienced intermittent right upper quadrant pain after meals for the last six months and had known asymptomatic gallstone for 10 years. He had chronic obstructive pulmonary disease and type 2 diabetes mellitus. On the physical examination, he had abdominal tenderness at the right upper quadrant and epigastrium on abdominal palpation. He had fever (38°C), and routine laboratory investigations were normal except for leukocyte count (15000/mm³).

Abdominal tomography and ultrasonography revealed a hydropic gallbladder with wall thickness of 6.5 mm, a localized (1 cm diameter) perforation to the liver bed and a 10 cm pear-shaped single gallstone (Figure 1).

After the diagnosis of acute cholecystitis, antibiotics (cefuroxime 1 x 2 g/day combined with metronidazole 2 x 500 mg/day), bowel rest, intravenous fluids, and proton pump inhibitors were given to the patient.

We performed ultrasonographic percutaneous cholecystostomy because of his comorbidities. Bile cultures, obtained during percutaneous cholecystostomy, revealed *E. coli*.

A negative clinical response to the initial treatment was defined because symptoms and signs did not regress, and temperature and white blood cell count were still high. Laparoscopic

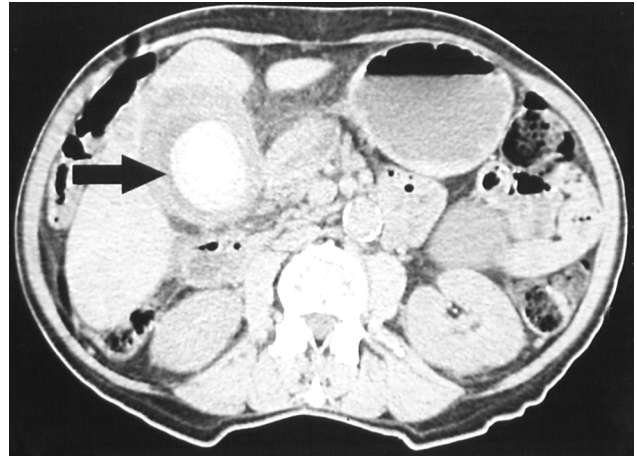


Figure 1. Arrow shows the giant stone

cholecystectomy was performed on the second day of hospital admission, but it was hard to handle and manipulate the gallbladder. In these circumstances, it was difficult to isolate anatomical structures and continue the operation. We converted to open cholecystectomy via right subcostal incision 15 minutes after initiation of operation. At the surgical exploration, the stone filled the gallbladder, which was difficult to manipulate as a result. First, a fundal incision was done to remove the stone from the gallbladder and a standard cholecystectomy was done. A limited perforation was seen in the liver bed of the gallbladder. We found a 10 cm single pear-shaped gallstone (Figure 2).

Light microscopic assessment revealed edematous gallbladder wall, inflammation with mixed type inflammatory cell infiltration, fibrosis and ulcers in gallbladder mucosa, diffuse metaplasia and Aschoff-Rokitansky sinuses. Also, histopathologic examination revealed chronic cholecystitis.



Figure 2. The giant gallstone

On the postoperative 5th day, the patient was discharged from the hospital without any surgical complication.

The stone presented here was predominantly white in color, containing black and dark green pigmented areas, with a smooth surface and semi-hard in consistency.

Although the usual sizes of gallstones mentioned in previous reports have ranged from millimeters to 5 cm in diameter, the stone found in our case is, as far as we know, the largest gallstone yet reported.

REFERENCES

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