Attendance to a "normal delivery" of choledocholithiasis

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Dear Editor,

We experienced an extremely fast delivery, which did not require episiotomy or lead to any complications. It was exciting to be there at that moment to watch the spontaneous migration of choledocholithiasis from the biliary tract to the duodenum.

A 51-year-old male was admitted in our hospital for control of acute and refractory epigastric pain; he had neither jaundice nor fever. Results of blood tests showed absence of leukocytosis, with total bilirubin level: 3.1 mg/dl [normal values (NV): 0.3-1.1]; direct bilirubin: 1.9 (NV: <0.25); aspartate aminotransferase: 637 U/l (NV: <50); alanine aminotransferase: 878 (NV: <50); gamma glutamyl transpeptidase: 484 U/l (NV: <55); and alkaline phosphatase: 210 U/l (NV: 30-120). Scans obtained via ultrasonography revealed presence of gallbladder sludge with normal biliary ducts and no lithiasis. Subsequently, the patient underwent an upper endoscopy, which revealed a protruding duodenal papilla, with a stuck lithiasis (Photograph 1). Based on these findings, we performed endoscopic retrograde cholangiopancreatography (ERCP) during the initial hours of admittance and detected an injured papilla with inflammation and mild limited bleeding signs (Photograph 2). There was no lithiasis at the choledochus, with normal caliber. Thus, we performed papillotomy, and there were no complications; at the end, there was a whole symptomatic relief after the maneuver.

Currently, there are retrospective studies analyzing parameters suggesting the spontaneous passage of choledocholithiasis to the duodenum (1) or in relation to clinical scenarios, either prospectively or retrospectively (2,

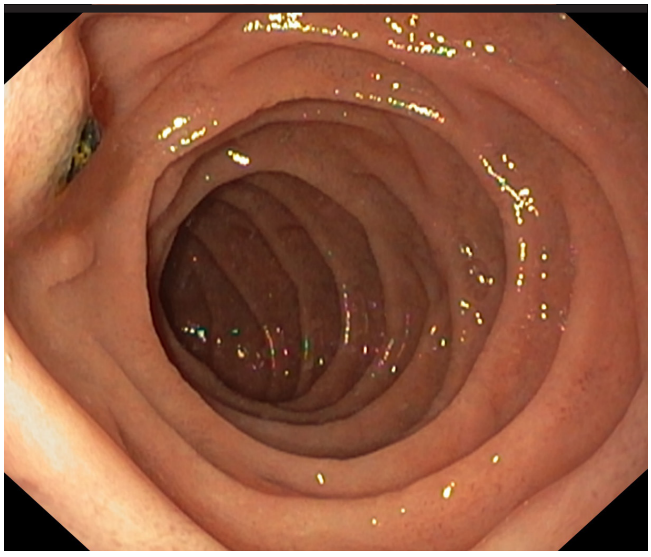

Figure 1. Protruding papilla with stuck stone.

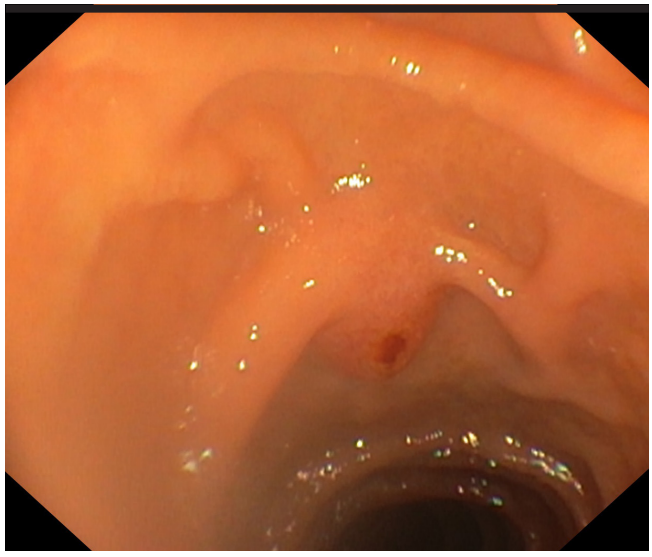

Figure 2. Inflammed papilla with mild bleeding.

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3). Moreover, there is only one report on live spontaneous migration of choledocholithiasis (4) and another on the passage during computed tomography (5). Conversely, in their study, Sakai et al wondered whether it is necessary to perform papillotomy in such cases (6). In our opinion, we believe that papillotomy should be performed to anticipate biliary events in a patient aged 51 years prior to cholecystectomy because of the presence of gallbladder sludge.

In this context, we have attended to a rare and curious clinical case, mimicking a "normal delivery".

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