BILE LEAKAGE POST CHOLECISTECTOMY. INJURY OF A REMNANT SURFACE BILE DUCT. AN UNUSUAL ANATOMIC VARIANT. CASE REPORT AND LITERATURE REVIEW.

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Background

Hepatobiliary tract has many variations in its anatomy, there is an usual pattern which is present around 50 - 60% of individuals, meaning that there is a variability of 50 - 40%.

One of those variations is the accessory hepatic duct which can arise from intra or extra hepatic biliary duct. Sometimes those variants can't be identified during the surgery and might be a source of bile leak following surgery.

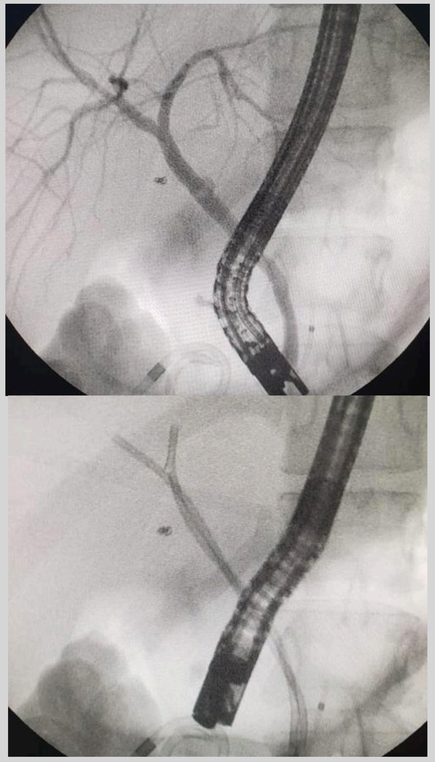
Those anatomical variants should be considered in any patient with bile leak identified post operatively.

Case Presentation

We present the case of a 42-year-old female who starts with abdominal pain and back pain at post-op (48 hours after laparoscopic cholecystectomy), mainly located at epigastrium.

We perform an abdominal CT that shows fluid in the pelvic cavity, surgical site without collections. As abdominal pain persists we decide to perform a cholangioresonance which rules out of bile leakage or collections.

Endoscopic ultrasound and transduodenal fine needle cholangiography is performed without evidence of leak. Same day of cholangiography bdominal pain keeps increasing and a control CT documents a retroperitonal collection greater than 200cc.



Percutaneous drainage is placed, obtaining 400 ml of bile fluid. The patient goes to ERCP and bile leakage is identified at the site of an aberrant left duct. Bile aberrant left duct injury is determined.

A sphincterotomy is performed and an 8 Fr stent is placed. Percutaneous drainage yields 400 ml in 24 hours. We perform another CT scan that shows enlargement of retroperitoneal collection, a second percutaneous drainage is placed obtaining bile fluid.

The stent is removed and a selective balloon cholangiography is performed at the confluence level, a patent bile duct is identified arising from the left hepatic duct, leak is identified at this aberrant bile duct at its distal portion.Left and right stents are placed by ERCP.

After the first 24 hours we observe an immediate decrease in percutaneous drainages output, abdominal pain decreases and nausea subsides. Bile stent are removed 6 days after placement.

Discussion

We decided to present the present case with the aim of showing an uncommon cause of bile leak due by an aberrant bile duct and its conservative management which allowed the resolution of the case without requiring aggressive surgical management that would increase the morbidity and mortality of the patient. We suggest to suspect or consider an accessory bile duct transection when identifying bile leak in the post operative of any patient who has underwent hepatobiliary surgery.

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