

INTRODUCTION

- Aberrant biliary anatomy includes duct of Luschka, accessory hepatic ducts, subvesical bile ducts.
- These significantly contribute to bile duct injuries during laparoscopic cholecystectomy.
- Recognizing Is key to preventing complications.

CASE PRESENTATION

- A 45-year-old female, with symptoms of RUQ pain and multiple episodes of vomiting along with elevated LFTs. She had a magnetic resonance cholangiopancreatography (MRCP) which did not reveal any choledocholithiasis or anatomical abnormalities. The patient underwent a laparoscopic cholecystectomy with intra-operative cholangiogram (IOC) and was noted to have the cystic duct inserting into the intrahepatic right duct. Due to contrast extravasation versus parenchymal blush from this area on the IOC (Fig 1), she underwent an endoscopic retrograde cholangiopancreatography (ERCP) which confirmed the aberrant anatomy (Figure 2). The patient recovered well without post-operative complications and remains asymptomatic at follow-up.

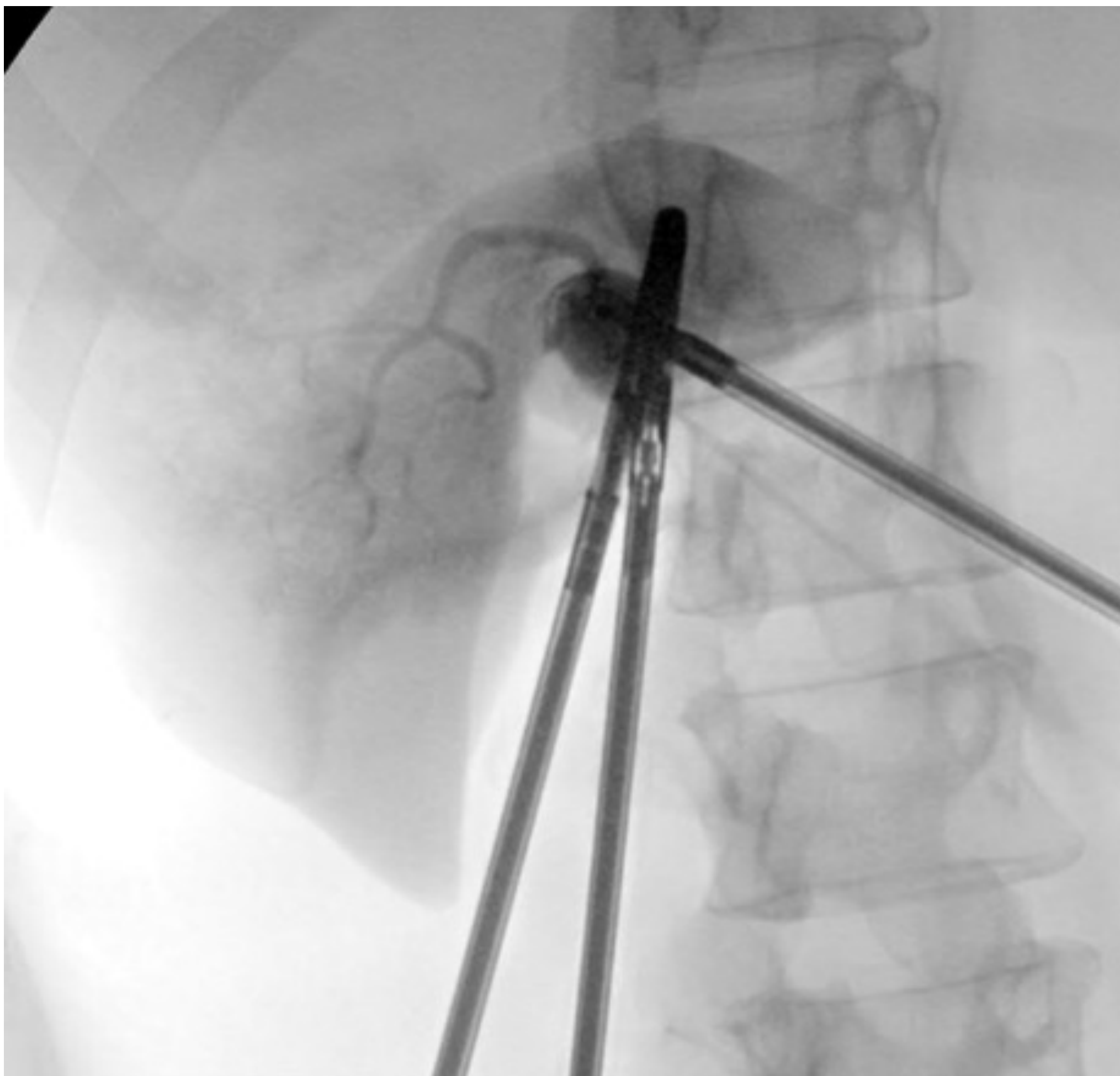


Figure 1: IOC WITH PRENCHYMAL BLUSH

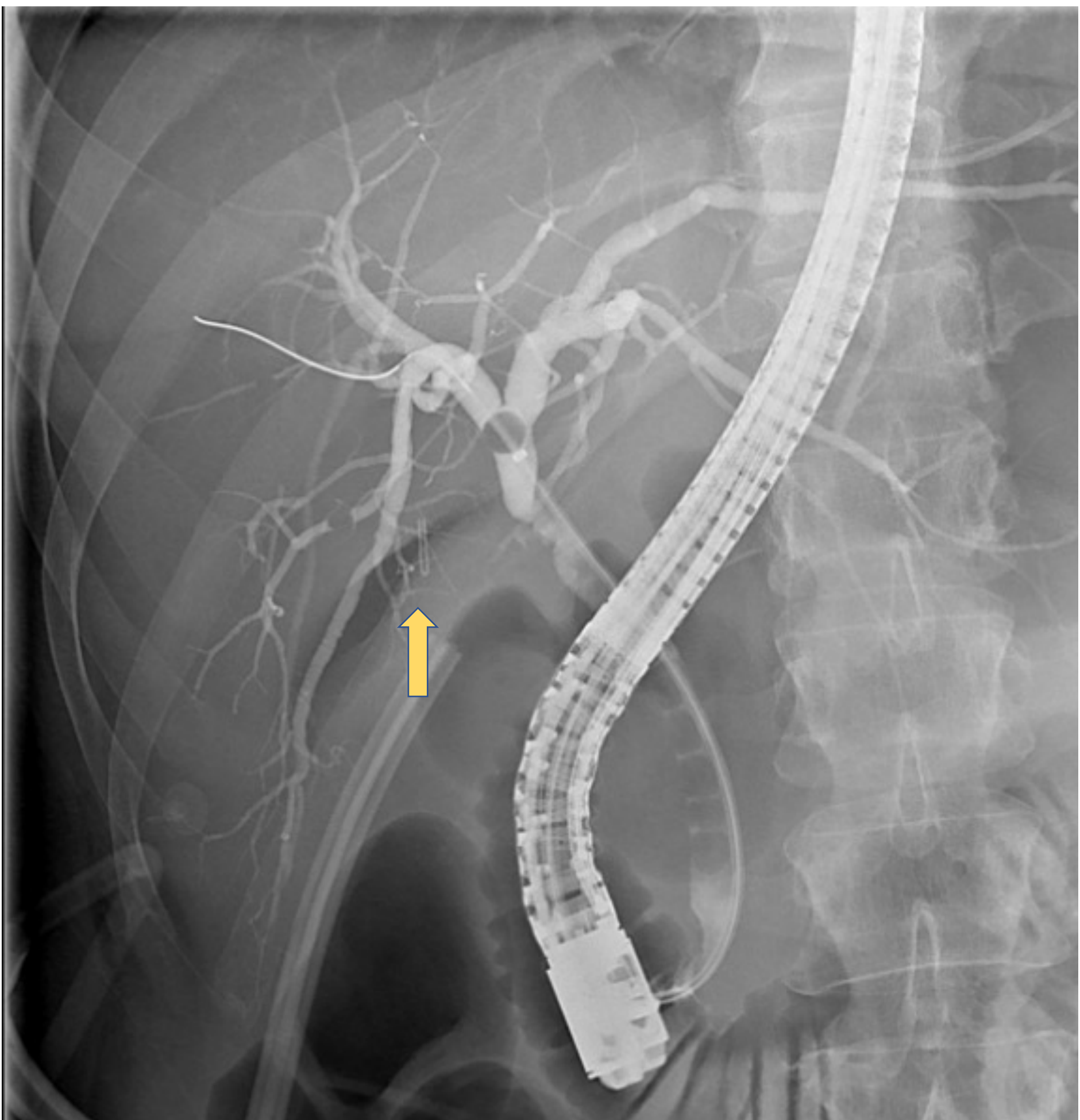
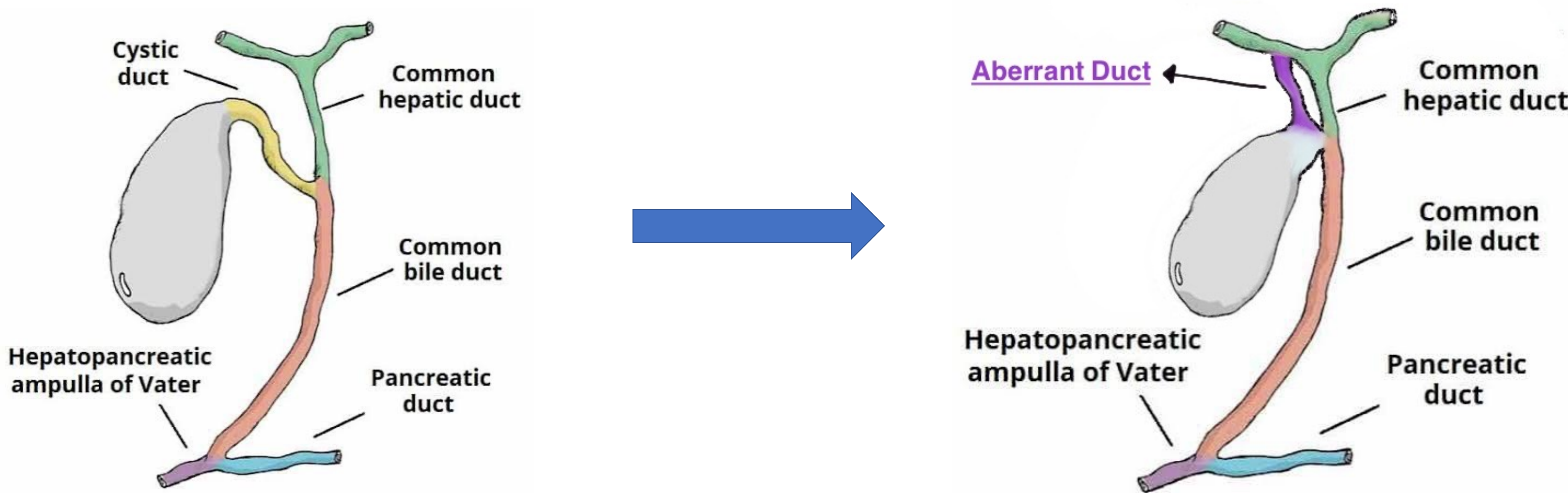


Figure 2: ERCP WITH CLIP AT ABERRANT INSERTION OF CYSTIC DUCT INTO INTRAHEPATIC RIGHT DUCT, YELLOW ARROW

DISCUSSION

- Rare variant: cystic duct -> Aberrant duct to right sided intrahepatic duct
- IOC enabled recognition of anomaly, ERCP confirmed anatomy
- Prevented major bile injury



CONCLUSION/ KEY TAKE AWAY POINTS

- Surgeons must be vigilant and maintain high index of suspicion for abnormal biliary anatomy.
- Liberal use of Intra-operative cholangiography remains essential for identifying anomalies.
- When in doubt, post-operative ERCP can be extremely useful.

REFERNCES

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CONTACT INFORMATION

EMAIL ID: vkavirayani@gmail.com; PHONE: +1(858)588-9209