To the Editors:

Unusual case of obstructive jaundice

Bleeding into the biliary tract was first described in 1654 (1), but the condition was termed 'haemobilia' in 1948 (1,2). The classical triad of gastrointestinal bleeding, right hypochondrial pain and jaundice suggest haemobilia (2). A majority of cases are due to trauma (50%) and operative trauma accounted for 15% (2). The procedure most likely to cause haemobilia is common bile duct exploration. It is a rare complication after cholecystectomy (3). We describe a case of haemobilia presenting as jaundice and upper gastrointestinal bleeding after open cholecytectomy.

A 58-year old man was admitted to Badulla General Hospital with a severe attack of colicky upper abdominal pain and tenderness over the right hypochondrium. Ultrasound scan of the abdomen demonstrated a gallbladder distended with many stones. Florid adhesions noted at the time of operation resulted in a difficult subtotal cholecystectomy, but his postoperative recovery was uneventful.

A month later, he was readmitted with jaundice, severe colicky right hypochondrial pain, and haematemesis. He was transferred to our unit for further management.

On admission he had features of obstructive jaundice, haematemesis and malaena. The liver was just palpable and tender, and the spleen was moderately enlarged. Other systems were clinically normal. Prothrombin time was 14 s with a control of 12 s. Gastroscopy was normal, but side-viewing endoscopy showed profuse bleeding through the ampulla and confirmed the diagnosis. Endoscopic retrograde cholangiogram (ERC) showed a filling defect in the common bile duct (CBD).

He underwent exploratory laparotomy. A pseudoaneurysm of the cystic artery at the cystic duct stump was resected. The filling defect seen in the cholangiogram was a firm mass of coagulated blood. The blood clot was removed and the the CBD was flushed with isotonic saline. T-tube drainage was carried out.

Jaundice subsided on the fifth postoperative day, but he was hypotensive persistently after the surgery, due to an acute anterolateral myocardial infarction and succumbed to it despite intensive treatment.

Bleeding at the ampulla of Vater during side-viewing endoscopy helps in the diagnosis of haemobilia (2,4). Since blood tends to remain separate from bile, a filling defect in ERC is characteristic (4). Post-cholecystectomy jaundice due to intra-choledochal blood clot has been reported previously in the literature (4). The source of bleeding in this patient was the pseudoaneurysm of the cystic artery. Selective hepatic angiography is used to detect the source of bleeding (2). Trans-arterial embolisation (TAE) using permanent agents is the current treatment of choice (2).

References

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