Cholecystocolic fistula demonstrated by barium enema: an uncommon cause of chronic diarrhoea


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Cholecystocolic fistulas are a rare disease, far less frequent than other bilio-enteric fistulas (8-13.6% of them, less than 0.7% of the biliary surgery) (1,2); when chronic, may often be asymptomatic for a long time, and a high grade of suspicion is necessary to get a correct diagnosis.

We report an unusual case whose clinical and radiological features make it instructive, and briefly review the pathogenesis, symptomatology, diagnosis, and treatment.

A 79-year-old woman, whose only relevant medical history was a non-operated cholecystitis 5 years ago, underwent barium enema (BE) because of chronic smelly diarrhoea and flatulence. Clinical and blood examinations revealed no abnormalities. The BE showed, after the complete colon was filled, a fistulous tract from the hepatic flexure to the cystic. The gallbladder was filled with air, and the complete biliary tree has a normal caliber. The next sequence was the picture of the duodenum, filled through the ampulla of Vater. Following ultrasonography (US) and computerized tomography (CT) showed the presence of cholelithiasis and pneumobilia, but failed to detect the fistulous tract. The patient refused any surgery or the performing of cholangiopancreatography (ERCP), and was treated with antibiotics, low fat-diet and fat soluble vitamins. Symptoms disappeared.

Etiology of cholecystocolic fistulas is diverse: tumors, parasitics, surgery, diverticular disease and, most frequently, complicated biliary lithiasis (more than 60% of them) (3). Most occur in elderly patients, without clear difference between sex.
The condition usually has a benign clinical course, although acute presentations such as cholangitis or obstruction of the colon can happen, with a difficult precise preoperative diagnosis in these cases. Symptoms are not specific: jaundice, fever, abdominal pain, vomiting, weight loss, flat intolerance and diarrhoea in selected reports. Due to this, diagnosis can be difficult: incidental pneumobilia may be the only manifestation, although sometimes is absent (4).

Patients with suspected bilio-enteric fistula are commonly investigated with US, upper gastrointestinal series, CT, BE and ERCP. The role of colonoscopy is uncertain (5).

Early elective cholecystectomy and primary repair of the fistulous tract is recommended to avoid cholecystitis or cholangitis. In non surgical patients, endoscopic sphincterotomy, by reducing biliary pressure, may be sufficient to achieve spontaneous closure of the fistula. Global mortality is between 10-15% (1).

REFERENCES