Obstructive jaundice for biliary mold due to foreign body

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CASE REPORT

We present a case of a 59 year old woman who was admitted to hospital in October 2009 for jaundice, abdominal pain, vomiting and fever of 38.5 °C, for one month of evolution. She reported a history of cholecystectomy because of multiple cholelithiasis and choledochotomy for removal of intracoledocal stones 24 years ago. The bile duct was closed on nylon tubing Kher 4 / 0 non-absorbable. Among the analytical data stood out: bilirubin, 3.9 mg / dl; ALP, 525 U / L (40-129); GGTP, 1313 U / L (8-61); GOT, 377 U / L (6-38); GPT, 909 U / L (6-41); lipase, 95 U / L (0-60) and ESR, 53 mm / h.

An abdomen ultrasound showed moderate dilatation of the main bile duct. Cholangiography was performed which revealed a common bile duct 13 mm in diameter with a tubular image of 30 x 5 mm inside that has a hyperintense core and leaving no acoustic shadow (Fig. 1). ERCP was made that aimed an intracoledocal filling defect of 30 x 5 mm (Fig. 2). After sphincterotomy, we passed the Fogarty ball and extracted several microstones. Then the cystic duct was channeled and passed the ball again without obtaining material. For the second time, the bile duct was cannulated and introduced the Dormia basket. An elongate, oblong, 3 cm in length biliary mold was extracted (Fig. 3). The pathology report corresponded to the suture with biliary debris.
The control RM after the therapeutic ERCP, revealed no pathological findings in the bile duct. The patient had a pancreatic reaction with amylase of 317 U/l (10-125) that was treated with fluids, analgesics and antibiotics (ertapenem). At discharge and several weeks later, she was without pain and liver function tests were normal.

DISCUSSION

Foreign bodies are a rare cause of obstructive jaundice. Observations have been published due to some food, parasites, fish bones, fragments of T tubes or other of rubber, shrapnel, metal clips, migrated stents, surgical gauze and non-absorbable suture material, which serve as a nucleus for the formation of stones or molds in the bile duct (1,2,3).

Currently therapeutic procedures on the biliary tract, ERCP and laparoscopic surgery, have reduced the use of suture material. Are still communicated cases of bile duct obstruction due to their use in biliary derivation and Kher tube drainage, even with absorbable material. The endoscopic removal after sphincterotomy by Dormia basket and the Fogarty ball is the treatment option for most of these patients, as occurred in our case (4).

REFERENCES