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EC GASTROENTEROLOGY AND DIGESTIVE SYSTEM

Short Communication

A Rare Cause of Biliary Reflux

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Question

A 50 – year old woman presented in our clinical practice due to epigastric pain and flatulence in the last 12 months. Her prior medical history was unremarkable. She had not recently taken any medication. The results of a physical examination and laboratory tests were normal.

Imaging assessment via real-time sonography of abdominal organs missed out the gallbladder; pancreas, liver, spleen and both kidneys showed normal appearance. Chest X-ray finding was also normal. Upper gastrointestinal endoscopy showed a biliary reflux, diffuse edema of stomach mucosa, wide pylorus with prolapse duodenal bulb mucosa (Figure 1).

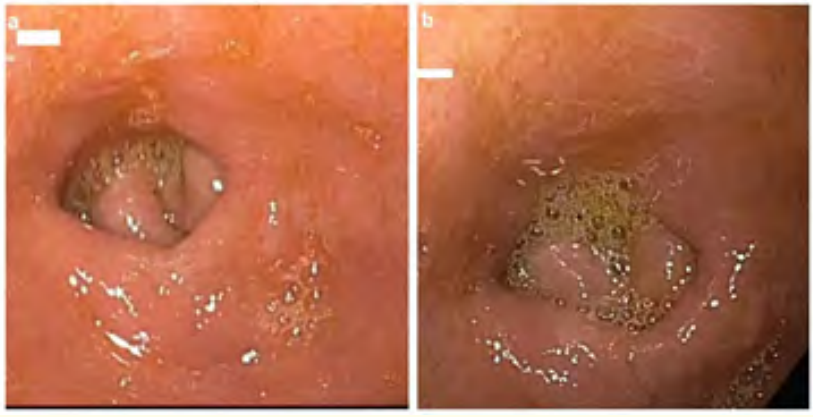

Figure 1: *(a) Endoscopic view of stomach antrum and pylorus, (b) prolapsing of duodenal bulb mucosa.*

What is the diagnosis?

Answer: Chronic biliobulbar fistula

A biliary fistula is an abnormal communication from the biliary system to an organ, cavity, or free surfaces. Internal biliary fistula could be bilioenteric, biliobiliary and bronchobiliary.

Bilioenteric fistula occurs because of inflammation with obstruction of the cystic duct resulting in adhesions of the gallbladder to the adjacent viscus such as duodenum, stomach and colon. The common causes of bilioenteric fistula include cholelithiasis, peptic ulceration, malignant neoplasm (gallbladder, bile duct, duodenum or stomach), Crohn's disease of the duodenum and paraduodenal abscess [1]. The symptoms and signs of these fistulas may range from non specific to life-threatening.

The bilioenteric type is rare and it's most common findings in radiology are pneumobilia and direct visualization of the fistula [2,3].

The computed tomography of abdomen in our case revealed pneumobilia followed with the bilioduodenal fistula (Figure 2) and excluded malignant pathology and lymphadenopathy.

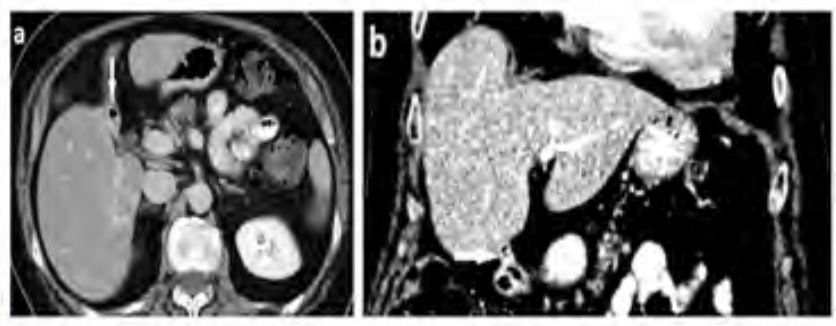

Figure 2: *Contrast enhanced computed tomography, (a) axial scan shows pneumobilia (white arrow), (b) coronal scan shows biliobulbar fistula (white arrow).*

The patient was undergo conservative treatment based on ursodeoxycholic acid 500 mg/day. One month after on the control exam there was absence of the meaningful symptomatology, the patient carried on with the conservative treatment.

Conflict of Interest Disclosure and Funding Declaration

Admir Kurtcehajic, Ervn Alibegovc, Ahmed Hujdurovic, Svjetlana Mujagic and Dzenita Kurtcehajic have no conflicts of interest or financial ties to disclose.

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