A 53-year-old woman underwent elective laparoscopic cholecystectomy for choledocholithiasis. Two days later, she presented abdominal pain, leucocytosis, and subhepatic collection on ultrasonography. The patient was referred for emergency laparoscopy with drainage of the collection. Around the 35th postoperative day, she developed a bilious enteric secretion through the drainage site (<Fig. 1>). Transcutaneous fistulography showed a biliary-colonic fistula, with contrast in the colon and biliary tract (<Fig. 2>). Endoscopic retrograde cholangiopancreatography (ERCP) was performed and confirmed the fistulography results (<Fig. 3>): a right hepatic duct fistula to the colon. A papillotomy was performed, and a 10Fr/12 cm plastic stent was inserted (<Fig. 4>).

At colonoscopy 35 days later, there was no sign of the fistula. Around the 40th day, a second ERCP was performed to remove the plastic stent. During this procedure, no evidence of the fistula was seen; the cutaneous fistula had also closed (<Fig. 5>). The patient had an uneventful recovery.

Biliary-colonic fistula is a very rare disease, usually secondary to a local infectious process or iatrogenic causes [1].

A very rare postcholecystectomy complication
most common types are the choledocho-
duodenal (70%) and the choledochoco-
lonic (26%) fistulae [2]. Clinical signs of
biliary-colonic fistula include right upper
quadrant pain, vomiting and nausea,
associated with or without peritoneal
signs, and even sepsis [3]. Diagnostic
management includes ultrasound, com-
puted tomography, percutaneous trans-
hepatic cholangiography, magnetic reso-
nance cholangiopancreatography, and
ERCP. The gold standard treatment is
surgical (open cholecystectomy and seg-
mental colonic resection) [2]. However,
ERCP and sphincterotomy may reduce
the intrabiliary pressure and help the fis-
tula to close itself. Such an approach can
be the treatment of choice in some cases
[4].
Very few cases of biliary-colonic fistula
have been reported in the literature, and
most of them were treated with surgery.
The case described here, however, was
treated successfully by using the ERCP
approach.

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Competing interests: None

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References
1 Rice JP, Spier BJ, Soni A. Preoperative diagno-
sis of cholecystocolonic fistula on ERCP. N Z
Med J 2010; 123: 69 – 72
2 Smyth J, Dasari BV, Hannon R. Biliary-colonic
fistula. Clin Gastroenterol Hepatol 2011; 9:
A26
3 Macedo FI, Casillas VJ, Davis JS et al. Biliary-
ocolonic fistula caused by cholecystectomy
bile duct injury. Hepatobiliary Pancreat Dis
4 Toll EC, Kelly MD. Successful management of
cholecystocolic fistula by endoscopic retro-
grade cholangiopancreatography: a report
of two cases. Hong Kong Med J 2010; 16:
406 – 408

Bibliography
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