

Isolated Gallbladder Tuberculosis with Postoperative Biliary Fistula

Tuberculous involvement of the gallbladder is rare. A case is reported here of gallbladder tuberculosis presenting as chronic cholecystitis, which revealed a gallbladder mass at surgery and in which postoperative biliary leakage developed.

A 28-year-old male laborer presented with a history suggestive of cholelithiasis. The physical examination and various investigations were essentially normal, except for the ultrasound examination, which showed multiple stones in a thick-walled gallbladder. At surgery, the patient was found to have a gallbladder mass of 8 × 6 cm in size, which contained thick pus with multiple stones and dense pericholecystic adhesions. Cholecystectomy with excision of the adherent colonic wall was undertaken. On the third postoperative day, the patient developed a biliary leak from

the drain site. Endoscopic retrograde cholangiopancreatography revealed the leak from the cystic duct stump (Figure 1). Endoscopic sphincterotomy was performed and over the next week, the leak ceased. Histopathological examination of the specimen revealed epithelioid granulomas with caseation necrosis and Langhans-type giant cells (Figure 2). The smear and culture did not reveal any tubercular bacilli. The patient was treated with antitubercular chemotherapy (rifampicin, isoniazid, pyrazinamide) and is doing well at two years, postoperatively.

Tuberculosis of the gallbladder is a rare occurrence. Bergdahl and Boquist reported three cases in 1972 and reviewed 41 cases of tuberculous cholecystitis in the literature (1). Stray case reports have also appeared in the literature since then. Gupta et al.



Figure 1: Endoscopic retrograde cholangiopancreatography showing the evidence of cystic duct blow-out.



Figure 2: Photomicrograph of the gallbladder with tuberculous granuloma showing caseation and Langhans giant cells and fibrous tissue.

reported on three patients with isolated biliary tuberculosis (2). The symptoms resemble other forms of gallbladder inflammation (1–3). Jaundice is not a common feature (2). At surgery, granulomatous pseudotumor simulates carcinoma, as in the present case. Isolation of tubercular bacilli from the resected specimen is rare (3). The routes of tuberculous infection of the gallbladder are hematogenous, lymphogenous, or direct (1).

Granulomatous lesions are known to disrupt when sutured, especially in the presence of distal obstruction. Biliary leaks have been managed with nasobiliary drainage, stents, or sphincterotomy (4). Cholecystectomy and antitubercular chemotherapy remain the mainstay of treatment of gallbladder tuberculosis.

*N. M. Gupta*¹, *A. Khaitan*¹, *V. Singh*²,
*B. Radotra*³

¹ Dept. of Surgery

² Dept. of Hepatology

³ Dept. of Pathology

Postgraduate Institute of Medical
Education and Research, Chandigarh,
India

References

1. Bergdahl L, Boquist L. Tuberculosis of the gallbladder. *Br J Surg* 1972; 59: 289–92.
2. Gupta NM, Chaudhary A, Talwar BL. Isolated biliary tuberculosis. *Asian Med J* 1985; 28: 636–40.
3. Leader SA. Tuberculosis of the liver and gallbladder with abscess formation: a review and case report. *Ann Intern Med* 1952; 37: 597–606.
4. Fouch PG, Harlan JR, Hoefer M. Endoscopic therapy for patients with a postoperative biliary leak. *Gastrointest Endosc* 1993; 39: 416–21.

Corresponding Author

N. M. Gupta, M.S.
Professor of Surgery
Postgraduate Institute
of Medical Education and Research
Chandigarh 160 012
India
Fax: +91-172-540401