A 28-year-old female was referred for surgical management of acute cholecystitis 1 day after endoscopic retrograde cholangiopancreatography (ERCP) and biliary sphincterotomy, because of the finding of a 15-mm-thick gallbladder wall on right upper quadrant ultrasonography (Figure 1). Pre-ERCP ultrasonography (Figure 2) and magnetic resonance cholangiopancreatography (Figure 3) demonstrated a 2.8-mm gallbladder wall and a patent cystic duct. The fluoroscopic images of the ERCP were reexamined and it was apparent that introduction of the guide wire had caused a dissection of the gallbladder wall which was visualized only after the injury had been exacerbated by injection of contrast material into the gallbladder wall with lifting of the mucosa off the muscularis demonstrated that the guide wire and catheter caused an intramural dissection during the ERCP.

The incidence of post-ERCP acute cholecystitis is less than 1 % [1,2]. The etiology has been postulated to be the presence of nonsterile contrast medium exacerbated by cystic duct obstruction and mechanical irritation [3–5]. This case represents the first reported occurrence of an intramural dissection of the gallbladder wall during ERCP. The subsequent intramural hematoma caused gallbladder wall thickening that mimicked post-ERCP cholecystitis on ultrasonography. While concurrent development of localized tenderness, fever, leukocytosis, and pericholecystic fluid on ultrasonography would strongly suggest post-ERCP cholecystitis, an isolated and sudden increase in gallbladder wall thickness after ERCP must be evaluated carefully for the possibility laparoscopic cholecystectomy for symptoms attributed to cholecystitis. A mural hematoma was seen upon initial visualization of the gallbladder (Figure 5) and confirmed by histopathology.
of an iatrogenic injury with the attendant risk of perforation.

References

Bibliography
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