

## A Case of Traumatic Cholecystectomy

A previously healthy 52-year-old man was admitted following a motor vehicle accident half an hour after lunch. He had been a back-seat passenger in the car, and during the collision was struck by collapsed front passenger seat in the right upper abdominal quadrant. On admission, he complained of intense pain in the abdomen and the right shoulder. One hour later, while being assessed by the surgical team, the symptoms increased and he developed respiratory distress. His blood pressure was 120/80mmHg and pulse 100/min. The abdomen was moderately tender to palpation, with guarding and reduction of peristaltic sounds.

Diagnostic peritoneal lavage was performed immediately and revealed intraperitoneal haemorrhage. At laparotomy, half an hour later, the abdominal cavity contained approximately 500mls of mixed clotted and unclotted blood.

The gallbladder was found between intestinal loops, completely detached from its liver bed, cystic artery and duct. The gallbladder was greenish with extensive ecchymosis and bile infiltration. There was no brisk bleeding from porta hepatis, but diffuse bleeding from linear disruptions and contusions of the gallbladder bed and surrounding liver area. The stump of the cystic artery was exposed and ligated and the redundant part of the cystic duct dissected, ligated and amputated. No other organ injuries were found. Drainage of Morrison's pouch was instituted because of advanced peritonitis. The subsequent course was uneventful and the patient was discharged from the hospital on the tenth post-operative day.

The gallbladder size was 8 x 5cm and the thickness of its wall 0.3 cm. The histologic report described mild lesions of chronic cholecystitis.

Only four cases of complete avulsion of the gallbladder (from liver, cystic artery and duct) were found in the available English-language literature since 1932<sup>1-3</sup>. The normal gallbladder is predisposed to injury when it is distended, pendulous or loosely attached to its bed<sup>3</sup>.

The mechanisms of injury include shearing forces, torsion and avulsion. All previously reported cases of traumatic cholecystectomy, like ours, were due to traffic accidents with crush-type injuries<sup>1-3</sup>.

The symptoms and physical signs are those of acute abdomen, depending on the extent of local and associated organ damage. Diagnostic delay<sup>1</sup> as long as 6 weeks has been reported. In the present case, however, our policy of diagnostic peritoneal lavage as routine after all blunt abdominal injuries with equivocal abdominal signs gave early diagnosis. The treatment of choice is cholecystectomy and, if there is complete traumatic avulsion of the gallbladder (as in our case) identification and ligation of the cystic duct and artery<sup>1-3</sup>. All associated injuries should be appropriately managed and drainage of Morrison's pouch carried out.

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### References

1. Ali M. Avulsion of the gallbladder in blunt abdominal trauma. *Injury* 1975;6 : 334.
2. Bosworth BM. Perforation of the small intestine from nonperforating trauma (Discussion section). *Am J Surg* 1948;76 : 481.
3. Brown PJ. Traumatic cholecystectomy. *Ann Surg* 1932;95 : 952-3.

## "Chap Kaki Tiga" a Possible cause of Upper Gastrointestinal Haemorrhage

We wish to report our retrospective study of an analgesic powder, Chap Kaki Tiga (CKT) which is associated with upper gastrointestinal haemorrhage (GIH). This study was carried out in Kapit Hospital,