

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 1932¹⁻³. The normal gallbladder is predisposed to injury when it is distended, pendulous or loosely attached to its bed³.

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 injuries¹⁻³.

The symptoms and physical signs are those of acute abdomen, depending on the extent of local and associated organ damage. Diagnostic delay¹ 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 artery¹⁻³. 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,

LETTERS TO THE EDITOR

Sarawak. A total of 107 cases of upper GIH were admitted over a two-year period (January 1991 to December 1992). Sixty-eight of these cases gave a history of prior ingestion of CKT. Four patients developed perforated gastric ulcers and needed emergency laparotomy with omentoplasty. Fifty per cent of the cases required emergency blood transfusion. All cases were given haematenics and H-2 receptor antagonists. On an average the upper GIH cases required to be warded for between 7-10 days.

The content of CKT analgesic powder is as follows:

	Old CKT	New CKT
Acetylsalicylic acid	52.8%	600 mg
Acetaminophen	27.2%	nil
Caffeine citrate	20%	nil

CKT is usually taken to relieve headaches, toothaches and generalised bodyaches. Many older patients have developed a habituation to the preparation and may take it a few times a day. This may be the cause of upper GIH, one of the most common emergencies

encountered in our hospital. Upper GIH comprised 5.52% of all surgical cases from January 1991 till December 1992.

Our records showed that about 97% of the upper GIH cases were admitted with a history of maelena and 86% with haemetemesis. Almost all cases have had prolonged periods of epigastric pain. The patients' ages ranged from 14 to 77 years with the 41-65 age group most commonly affected. The male to female ratio was 5:1. Most cases occurred during the rice planting season (November - December) and the harvesting season (March - May), reflecting perhaps, the greater usage of the preparation with increased physical labour. Aspirin in CKT is most likely the cause of the gastric bleeding. Doctors in Malaysia should be aware of this problem.

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