Abstract:
An anterior abdominal wall abscess due to spontaneous rupture of gall bladder is being presented because of its rarity in the present century. In the 19th century many cases have been reported. But nowadays because of early recognition of symptoms of cholecystitis and better imaging modalities, cholecystitis is being treated before such complications arise.

Keyword: Cholecystitis, Abdominal wall abscess, gall bladder rupture

CASE REPORT:
A 75 years old gentle man was admitted for the complaints of swelling in the right upper abdomen for the past 1 month and on and off fever. He was a diabetic. Clinical diagnosis of parietal wall abscess was made. Blood investigations were normal except for the elevated blood glucose level. Ultrasonogram also supported our diagnosis.

So, incision and drainage was done. During which along with 10 cc of pus, 5 smooth surfaced gall stones were retrieved through the incision site. Post procedure CT abdomen was taken which showed calculus cholecystitis with minimal pericholecystic collection with adjacent parietal wall abscess and no free fluid in the abdomen. As the tract has been spontaneously sealed off and there are no signs of peritonitis, planned for elective cholecystectomy after 6 weeks, during which the patient was under the coverage of antibiotics and his diabetic was controlled. After 6 weeks open cholecystectomy was done through Kocher’s incision. The gall bladder was found to be densely adherent to the anterior abdominal wall at the fundus. Histopathological examination of the gall bladder showed chronic inflammation. Post operative was uneventful and the patient was discharged after 14 days.
Gall Stones removed during I & D
CT Abdomen of the patient showing GB Calculi with adjacent Anterior Abdominal Wall Abscess

DISCUSSION:
Thilesus first described cholecystocutaneous fistula in 1670. Prior to 1900, 3 large series were published in quick succession, including a report by Courvoisier in 1890 (169 of 499 cases of gallbladder perforation), 1 by Naunyn in 1896 (184 cases), and another by Bonnet in 1897 (122 cases). Henry and Orr reported 36 cases, of external biliary fistulae. But in the late twentieth and 21st century only few cases are reported. Rarity of this occurrence today is probably due to early diagnosis of gallstone disease by ultrasonography, broad spectrum antibiotics and prompt surgical intervention.

ETIOLOGY:
This condition is invariably a complication of neglected gallstone disease, although isolated case reports have described spontaneous cholecystocutaneous fistula due to carcinoma of the gallbladder and acalculous cholecystitis. In addition, retained gallstones following laparoscopic cholecystectomy may cause biliary fistula or abdominal wall sinuses. Salmonella typhi, which has a predilection for the gallbladder, can cause chronic cholecystitis and may predispose the patient to spont aneous cholecystocutaneous fistula. Polyarteritis nodosa with gallbladder vasculitis and steroid use causing immunosuppression also may be associated with the condition.

PATHOPHYSIOLOGY:
Gallbladder is almost always obstructed. Pressure within gall bladder rises, impairing the vascular supply, causing focal areas of necrosis. Perforation of the gallbladder may occur, causing a localized cholecystic abscess. The perforation usually occurs via the fundus of the gallbladder, as this is the farthest from the cystic artery or at the neck from pressure necrosis due to the impacted calculus. The abscess may resolve, may perforate into an adjacent viscus like duodenum, stomach, colon, or into common bile duct or penetrate the abdominal wall leading to parietal wall swelling which may spontaneously rupture, forming a fistula with drainage onto the skin. The draining sinus tract usually present in the right upper quadrant of the abdomen, but this tract may alternatively drain to the right iliac fossa, right groin, right gluteal region, umbilicus or left upper quadrant.
TREATMENT:
All patients should be treated with antibiotics because of associated sepsis, cholecystitis, oremyema. However, antibiotics are an adjunctive therapy and should not be the only treatment. Both the gallbladder and fistula need to be resected to achieve a cure. However, as this condition commonly occurs in elderly patients who may have multiple medical comorbidities, surgical treatment must be tailored depending on the patient's fitness for surgery.

CONCLUSION:
In conclusion, this case underlines the fact that all patients, especially elderly and immunocompromised individuals presenting with right-sided abdominal wall abscesses need to be investigated thoroughly for underlying pathology, particularly on a background of calculous biliary tract disease, as in these patients symptoms of recurrent cholecystitis may not be typical, like this case, where diabetes may have masked the symptoms.

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