Medical Memoranda

Acute Pancreatitis Complicating a Choledochal Cyst

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Douglas (1852) appears to have been the first to describe the pathological and clinical features of choledochal cyst. It is not a common condition; Maingot (1964), in a review of the literature, noted that 450 authentic cases had been reported. The complications of choledochal cyst are largely due to biliary obstruction, and include stone formation, suppurative cholangitis, hepatic abscess, biliary cirrhosis, and thrombosis of the portal vein (Rogers and Priestly, 1949; Alonso-Lej *et al.*, 1959). Spontaneous or traumatic rupture of the cyst may occur, and over 20 cases of rupture during pregnancy have been reported (Maingot, 1964).

The following case is unusual in its mode of presentation. The patient suffered repeated attacks of acute pancreatitis before a cystic mass was found in the right upper quadrant of the abdomen. The preoperative diagnosis was that of a pancreatic pseudocyst.

CASE REPORT

The patient, aged 27 years, was admitted to the Liverpool Maternity Hospital on 29 April 1968. She was then 31 weeks pregnant and complained of right subcostal pain and severe back-ache together with nausea and vomiting. Acute pancreatitis had been diagnosed at laparotomy for suspected appendicitis in 1963, when she was admitted to Bootle Hospital. Her symptoms subsided

FIG. 1.—Choledochal cyst outlined by sodium diatrizoate.

soon after admission to Liverpool Maternity Hospital; but during her stay in the antenatal ward she had four further similar episodes, and in one of these the serum amylase was 2,000 Somogyi units per 100 ml. Each time she recovered with conservative treatment, including antibiotics and intravenous fluid therapy. She went into spontaneous labour on 13 May, and was delivered of twins the same evening.

During the puerperium a smooth cystic mass was found palpable in the right upper quadrant of the abdomen. The diagnosis of a

pancreatic pseudocyst was made. A cholecystogram at this time showed complete non-function of the gall bladder.

She was admitted for surgery at the Royal Infirmary on 7 August. On this occasion the serum amylase was 88 Somogyi units per 100 ml., the serum bilirubin was 0.8 mg./100 ml., and the flocculation tests were normal.

At laparotomy on 9 August a large choledochal cyst was found to arise from the supraduodenal portion of the common bile duct. Its wall consisted of chronically inflamed dense fibrous tissue. The cyst contained 700 ml. of bile, and is seen in Fig. 1 outlined by Hypaque (sodium diatrizoate). The pancreas was noted to be chronically inflamed. A cystoduodenostomy was performed.

On the fourth postoperative day the patient developed intermittent pyrexia, rigors, and jaundice (serum bilirubin 4.5 mg./100 ml., direct positive van den Bergh). A diagnosis of acute cholangitis was made. A straight x-ray film of the abdomen showed gas in the biliary tree (Fig. 2). She recovered with intramuscular

FIG. 2.—Straight x-ray film showing gas in the biliary tree.

tetracycline and intravenous fluid therapy and has since been symptom-free.

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