Hemorrhagic Cholecystitis: A Rare Cause of Presentation with Upper Gastrointestinal Bleeding

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ABSTRACT

Hemorrhagic cholecystitis represents a rare cause of upper gastrointestinal bleeding, often not appreciated in the first instance upon presentation. A 73-year-old Caucasian female presented with a 48 hour history of vomiting and melaena. No associated abdominal pain, fevers or jaundice and no history of any similar episodes described. She was on prophylactic Rivaroxaban after recent right hip replacement. She presented apyrexial with normal hemodynamic parameters. Abdominal examination was unremarkable including negative Murphy’s sign. Liver function tests were deranged (bilirubin 55 total, 36 conjugated, ALP 696, GGT 383, ALT 1390, AST 2140), Hb 96 and inflammatory markers raised: WCC 13.8, CRP 114. Coagulation profile was elevated INR 1.4, PT 15, APTT 30. CT abdomen confirmed perforated calculous cholecystitis with heterogenous gallbladder content and loss of integrity of gallbladder wall inferiorly. The patient progressed well on conservative management with IV antibiotics. Anticoagulation was recommenced once Hb observed to be stable. She underwent elective laparoscopic cholecystectomy 8 weeks later. The current literature, with a small number of case reports, supports this management. This presentation highlights the importance of thorough initial assessment including indicated imaging to diagnose and treat rare and challenging manifestations such as hemorrhagic cholecystitis.

Keywords: Hemorrhagic, Cholecystitis, Upper, Bleeding

1. INTRODUCTION

Hemorrhagic cholecystitis represents a rare cause of upper gastrointestinal bleeding and is often not appreciated in the first instance upon presentation [1,2]. We describe an usual case of hemorrhagic cholecystitis presenting as melaena, with review of the relevant literature available.
2. CASE REPORT

A 73-year-old Caucasian female, living independently, presented to the emergency department with a 48 hour history of vomiting and melaena. She had no associated abdominal pain, fevers or jaundice and there was no history of any prior similar episodes of melena. She denied history of reflux, smoking, steroid or NSAID use. Her past medical history included recent right total hip replacement 4 weeks prior, discharged on prophylactic dose of Factor Xa inhibitor rivaroxaban. Further history of note included a previous out-of-hospital cardiac arrest secondary to ST elevation MI in 2015, survived owing to prompt access to percutaneous coronary intervention. She has no history of any previous abdominal operations. On examination, she was apyrexial and hemodynamic parameters were normal. Abdominal examination was unremarkable, including negative Murphy’s sign. There were no clinical signs of chronic liver disease or portal hypertension. Biochemistry revealed deranged liver function test (LFT) particularly a conjugated hyperbilirubinemia (bilirubin 55 total, 36 conjugated, ALP 696, GGT 383, ALT 1390, AST 2140). Hb 96 and raised inflammatory markers WCC 13.8, CRP 114 also noted. Coagulation profile was normal with INR 1.4, PT 15, APTT 30. Portal venous phase CT abdomen confirmed perforated calculous cholecystitis. The gallbladder content was ‘swirled’ and heterogenous, with loss of integrity of gallbladder wall inferiorly and adjacent duodenal D1/D2 inflammation (Figure 1&2).
The patient progressed well on conservative management with intravenous antibiotics (ampicillin, gentamicin and metronidazole) until inflammatory markers and LFT normalised. During this period of time, therapeutic anticoagulation was withheld, with prophylactic doses of low molecular weight heparin (LMWH) given until observed to have no clinical indication of ongoing bleeding. Elective interval laparoscopic cholecystectomy was performed in 6 weeks after this admission, with normal intraoperative cholangiogram and no other immediate or delayed complications.

3. DISCUSSION

The present literature, though limited to a small number of other case reports, supports this management. Except for one other case, all described incidences of haemorrhagic cholecystitis on review of the literature presented with right upper quadrant pain [3] or with intra-peritoneal bleeding [4], rather than an entirely painless presentation with upper GI tract bleed as in this case.

4. CONCLUSION

This case highlights the importance of thorough initial assessment including indicated imaging to diagnose and treat rare and challenging manifestations such as haemorrhagic cholecystitis. Increased awareness of this unusual cause of upper intestinal bleeding is also gained.
REFERENCES