Gallbladder in the Left Side of the Lower Abdomen

Precise knowledge of the anatomical structures is very important when diagnosing and treating gallbladder and bile duct diseases (1). Ectopy of the gallbladder is a rare anomaly, which may cause difficulties in establishing the diagnosis.

A 56-year-old woman was examined due to pain under the right costal arch. Abdominal ultrasonography demonstrated a cystic structure under the liver. At panendoscopy, an arcuate impression was seen on the prepyloric major curvature of the antrum, continuing on the duodenal bulb. Abdominal radiography revealed that the stomach was located on the left of the spine. The duodenum was dislocated by an apple-sized mass. Cholescintigraphy showed a non-filling gallbladder and angulation of the common bile duct. A CT scan showed a structure filled with fluid, beginning at the hepatic portal level, running medially, and hanging 5 cm deep from the iliac crest level into the minor pelvis. It was suspected that it was an atypically located edema of the gallbladder.

At endoscopic retrograde cholangiopancreatography (ERCP), the papilla of Vater was identified in an atypical location (Figure **1**). The pancreatic duct had a normal appearance, and the intrahepatic and extrahepatic bile ducts were of normal diameter. The course of the hepatic bile duct was angled medially. The cystic duct originated from the common hepatic duct and then ran medially, along the line of the spine. The lower pole of the enlarged gallbladder was visible on the left side of the true pelvis. The gallbladder contained a single stone, 20 mm in diameter (Figure **2**).

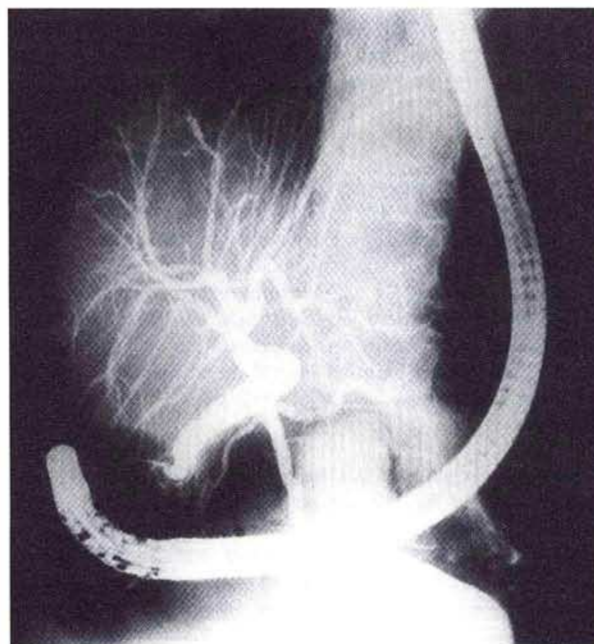

Figure 1: A normal ERCP, showing the bile ducts with a normal diameter.

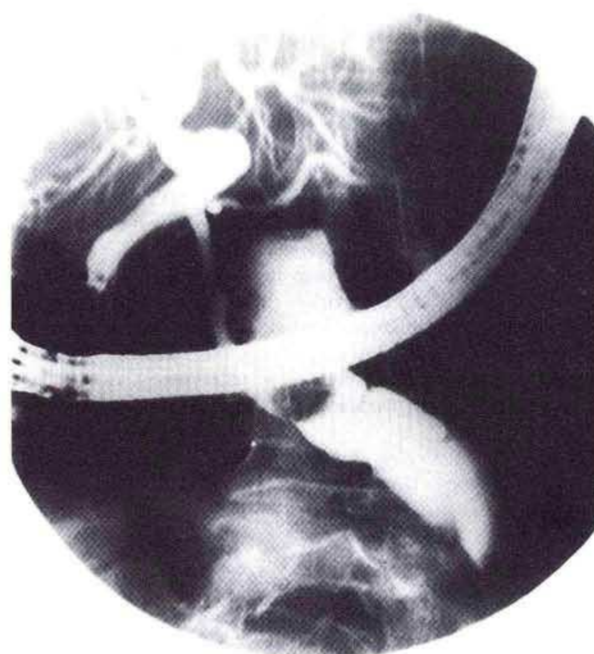

Figure 2: ERCP: a stone is visible in the atypically located gallbladder.

The patient's abdominal complaints were caused by cholelithiasis. At surgery, the findings corresponded to the ERCP image. The markedly dilated gallbladder was located in a peritoneal duplication, hanging deeply into the true pelvis. The peritoneal duplication was incised, and the duodenum adhering to the common bile duct was freed. Cholecystectomy was performed, and intraoperative cholangiography was negative.

It may happen that abdominal ultrasound fails to demonstrate the gallbladder, and among other reasons, this may be due to an atypical location of the gallbladder. Ectopy of the gallbladder is a congenital anomaly (1). In our opinion, ERCP is indicated when noninvasive methods fail to confirm the diagnosis in suspected diseases or congenital anomalies of the biliary ducts and gallbladder.

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Reference

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