Laparoscopic cholecystectomy is gaining increasing acceptance as a mode of minimally invasive surgery. We describe a peculiar gynecologic complication following uncomplicated laparoscopic cholecystectomy. Our patient presented with a four-month history of subacute pelvic pain, primarily located in the right lower quadrant, two years after laparoscopic cholecystectomy. Diagnostic laparoscopy revealed a hemaclip embedded in the right ovarian capsule of an otherwise normal pelvis. The hemaclip had probably dislodged from its original site of placement in the upper abdomen, and migrated to the dependent portions of the pelvis, where it implanted in a follicular stigma and became affixed to the ovarian capsule. The hemaclip was removed without complications, and the patient’s symptoms improved.

Introduction

Symptomatic cholelithiasis is classically treated by cholecystectomy accompanied by cholecystectomy. Recent technological advances have led to new nonsurgical and surgical options (1). Laparoscopic cholecystectomy has recently emerged as a minimally invasive surgical technique with the advantages of decreased postoperative pain, quicker recovery, and improved cosmetic results as compared to standard techniques (2, 3).

The most frequent complications associated with laparoscopic cholecystectomy include bile leakage, damage to the common bile duct, hemorrhage, and damage to other intra-abdominal organs (4, 5). This report describes a unique gynecologic complication following uncomplicated laparoscopic cholecystectomy.

Case Report

The patient was a 25-year-old woman (gravida II, para II) who presented two years following uncomplicated laparoscopic cholecystectomy with a four-month history of pelvic pain, principally located in the right lower quadrant. She described the pain as a nonradiating, intermittent stabbing pain that started at midcycle and lasted until the completion of her menses. The patient’s past medical history was significant only for the history of laparoscopic cholecystectomy. Her gynecologic history revealed normal, regular menses, with no history of sexually transmitted diseases. Physical examination and laboratory data were normal. Diagnostic laparoscopy revealed a hemaclip embedded in the capsule of the right ovary (Figure 1) in an otherwise normal pelvis. The hemaclip was removed at the time of laparoscopy without complication. The subject noted a gradual diminution of symptoms during the first two postoperative months. At six months of follow-up she noted almost complete resolution of her symptoms, except for mild mittelschmerz for one day.

Discussion

Ovulation results in cyclic disruption of the ovarian capsule, providing the opportunity for foreign substances to gain access to ovarian tissues. This disruption of the ovarian capsule is felt to play a role in the pathophysiology of ovarian abscesses by allowing micro-organisms access to the intra-ovarian environment (6).

In this report, we describe a sequela of laparoscopic surgery in which a hemaclip was embedded in the ovary. The hemaclip probably dislodged from its site of placement in the upper abdomen, migrated to the dependent portions of the
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peritoneal cavity, and embedded in the ovary at a follicular stigma. In addition to causing pain, a foreign body of this type could potentially elicit an inflammatory reaction, resulting in adhesion formation and a reduction in the patient’s fecundity.

Recent technological advances have resulted in the development of nonsurgical approaches to the treatment of symptomatic cholelithiasis. These treatments are advantageous for radiolucent cholesterol gallstones which comprise over 80% of gallstones in industrialized countries. These therapies include lithotripsy (7), oral dissolution agents (8), and percutaneous (9) or endoscopic contact dissolution agents (10). In a woman of reproductive age with a desire for future fertility, one must consider nonsurgical interventions as a viable method for the elective treatment of cholelithiasis.

References


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