Laparoscopic cholecystectomy for symptoms attributed to cholecystitis. A mural hematoma was seen upon initial visualization of the gallbladder (Figure 5) and confirmed by histopathology. The incidence of post-ERCP acute cholecystitis is less than 1% [1,2]. The etiology has been postulated to be the presence of nonsterile contrast medium exacerbated by cystic duct obstruction and mechanical irritation [3–5]. This case represents the first reported occurrence of an intramural dissection of the gallbladder wall during ERCP. The subsequent intramural hematoma caused gallbladder wall thickening that mimicked post-ERCP cholecystitis on ultrasonography. While concurrent development of localized tenderness, fever, leukocytosis, and pericholecystic fluid on ultrasonography would strongly suggest post-ERCP cholecystitis, an isolated and sudden increase in gallbladder wall thickness after ERCP must be evaluated carefully for the possibility of iatrogenic injury.

**Figure 1** Ultrasonography performed 1 day after the endoscopic retrograde cholangiopancreatography (ERCP) revealed a gallbladder wall thickness greater than 15 mm with no pericholecystic fluid.

**Figure 2** Ultrasonography performed 4 days before ERCP demonstrated a normal gallbladder wall thickness of 2.8 mm.

**Figure 3** Magnetic resonance cholangiopancreatography performed 3 days before ERCP demonstrated a patent cystic duct and good visualization of the gallbladder.

**Figure 4** The initial fluoroscopic image obtained after the guide wire was placed into the gallbladder does not reveal the injury. Infiltration of contrast material into the gallbladder wall with lifting of the mucosa off the muscularis demonstrated that the guide wire and catheter caused an intramural dissection during the ERCP.

**Figure 5** Laparoscopy demonstrated a grayish-blue discoloration of the gallbladder consistent with an intramural hematoma.
of an iatrogenic injury with the attendant risk of perforation.

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