



Case Report

Endoscopic Management and Avoiding Early Surgery in a Rare Case of Type I Mirizzi’s Syndrome

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Introduction

Mirizzi’s syndrome is a rare presentation of gallstones and obstructive jaundice. It occurs when one large stone or multiple small stones get impacted in the Hartman’s pouch or at the cystic duct causing obstruction of the common hepatic duct by external compression. The patient may present with jaundice, fever, right upper quadrant pain. Septic shock can occur Although it’s a rare complication. Early diagnosis with clinical suspicion will prevent further operative management. Also it prevents biliary ductal injuries. We present a case that was successfully treated with endoscopic management [1-5].

Case Report

A 45-year-old male, presented to the emergency department with a history of fever, abdominal pain and jaundice for 2 weeks. He was found in septic shock, admitted to Intensive Care Unit. Blood cultures were positive for *K. pneumoniae*, CT of the abdomen and pelvis showed hepatomegaly, severe diffuse hepatic steatosis, no biliary duct dilation and cholelithiasis. MRCP demonstrated a small non-obstructing distal CBD calculi. The gastroenterology

team performed a EUS and ERCP; it was remarkable for stones in the gallbladder neck and one stone in the distal CBD associated with 10mm dilation, findings suggestive of Mirizzi’s syndrome type I. He had a successful sphincterotomy and balloon extraction of CBD stones with evidence of bile flow, no stents were required (Figure 1 and 2).

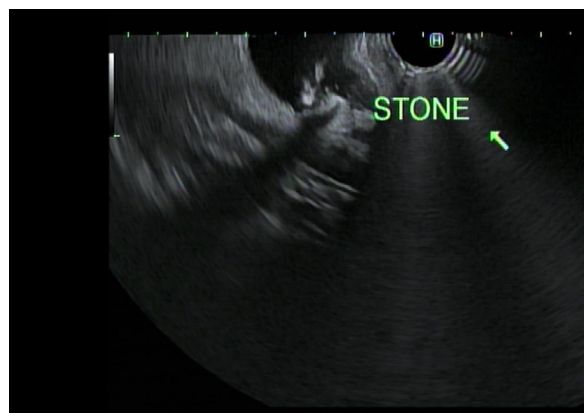


Figure 1: Sphincterotomy and balloon extraction of CBD stones.

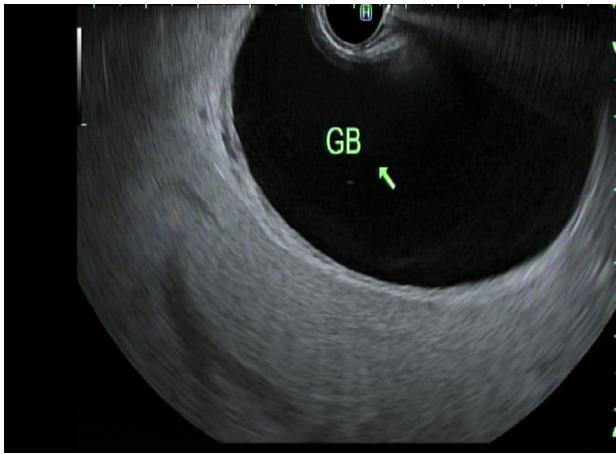


Figure 2: Sphincterotomy and balloon extraction of CBD stones with evidence of bile flow.

Discussion and Conclusion

Mirizzi's syndrome is estimated to be between 0.05 to 4 percent of all patients undergoing surgery for cholelithiasis. Mirizzi's syndrome can be mistakenly diagnosed as cholangiocarcinoma. Mirizzi's syndrome can present with fever, abdominal pain and jaundice. It can also be associated with acute cholangitis and pancreatitis. Diagnosis of Mirizzi's syndrome can be suspected in any patient that presents with the mentioned symptoms with presence of an impacted stone in the gallbladder neck with dilation of biliary duct. In our case, we performed an EUS/ERCP as diagnostic and therapeutic management. ERCP and sphincterotomy allows for biliary decompression with or without stenting in a patient with obstructive jaundice as in this case. Surgery is the definitive therapy for Mirizzi's syndrome; surgery

can be avoided early in the disease course especially in patients with poor surgical candidacy. In our case patient clinically improved after treatment. He was instructed to complete the treatment for bacteremia. He was scheduled for elective cholecystectomy outpatient [6-10].

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