中文題目：潰瘍引起之總膽管十二指腸廔管併發急性膽管炎:個案報告

英文題目：Acute Cholangitis Secondary to Ulcerogenic Choledochoduodenal Fistula : A Case Report

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Background:

Choledochoduodenal fistulas(CDDF) are very rare and in most cases are caused by a long-lasting and poorly treated chronic duodenal ulcer. They often present without specific clinical symptoms and may be incidentally picked up by symptoms of ulcer disease, by attacks of cholangitis or bleeding or vomiting in cases of ductoduodenal stenosis. Another more common types of fistula is cholecystoduodenal fistula (CCDF) which is generally associated with gallbladder disease. The prognosis is poor in the biliary enteric fistula secondary to gall-bladder disease and its treatment of choice is undisputedly surgical. The prognosis is good in ulcerogenic fistula, so its treatment still remains controversial.

We report a man with a long history of duodenal ulcer disease and congestive heart failur who developed acute attack of cholangitis.

Case Report:

The patient is a 66-year-old man who had a long history of duodenal ulcer disease. This time, she suffered from tarry stool, fever and RUQ abdominal pain for one day. He was brought to our ER and then admitted to ward under the tentative impression of UGI bleeding and acute cholangitis.

After admission, the patient received proton pump inhibitor therapy with pantoprazole for UGI bleeding. Empiric antibiotic therapy with ceftazidime plus metronidazole was also prescribed for acute cholangitis with sepsis. In addition, the patient received the examination of upper GI panendoscopy at the next day. An duodenum ulcer about 2cm over the inferior wall of the bulb and two fistula like lesions over the inferior wall of the bulb were seen in the upper GI panendoscopy. Ultrasonography and abdomen CT showed pneumobilia. Choledochoduodenal fistulas was found by upper gastrointestinal barium study. After the medical conservative treatment, the patient was finally discharged without complication.

Discussion:

Penetrating duodenal ulcer disease in patients with a long ulcer history accounts for up to 80% of choledochoduodenal fistula. Barium studies can be used to demonstrate such a fistulous communication but the appearances should be distinguished from reflux of barium through the ampulla of Vater. In case of reflux the common bile duct

fills only in its distal portion, whereas there is usually filling of the intrahepatic ducts in choledochoduodenal fistula. Another radiological finding that can be seen in such biliary enteric fistulas is pneumobilia which is the presence of air in the biliary tree.

Treatment of choledochoduodenal fistula secondary to duodenal ulcer stands divided between prophylactic surgery and conservative medical therapy. Although its treatment still remains controversial, recent consensus acknowledges treatment of the ulcer disease itself as the major goal and suggests surgical intervention in high risk or asymptomatic patients only for the usual indications in peptic ulcer disease, that is, hemorrhage, obstruction or intractability.