We report the case of a 73-year old female patient with a history of chronic cholecystitis with a palpable mass extending from the right hypochondrium to the right iliac region. An abdominal ultrasound showed an enlarged gallbladder extending to the right iliac region with multiple gallstones confirmed by computed tomography scan.

An exploratory laparotomy was performed. A giant gallbladder with thickened walls and presence of adhesions to the neighbor organs that were difficult to remove were found and required drainage. A conventional cholecystectomy was performed using the Pribram’s technique. A surgical specimen measuring 15 x 10 cm was sent to the pathologist who made a diagnosis of chronic cholecystitis. This case is an atypical presentation of chronic cholecystitis due to a giant gallbladder.

**RESUMEN**

Se registra el caso de una paciente femenina de 73 años con antecedente de colecistitis crónica, quien al examen físico presentaba una tumoración palpable en hipocondrio derecho que se extendía a fosa ilíaca derecha. La ecografía abdominal mostró aumento del tamaño vesicular que alcanzaba fosa ilíaca derecha con contenido multilitiásico; se confirmó dicho hallazgo con estudio tomográfico. Se realizó laparotomía exploradora con hallazgo operatorio de vesícula gigante de paredes engrosadas, tensa, adherida a órganos circundantes, de dificultosa disección, que requirió punción para drenaje de su contenido. Se efectuó, además, colecistectomía convencional según técnica de Pribram, y se obtuvo una pieza quirúrgica de aproximadamente 15 x 10 cm, con informe de anatomía patológica de colecistitis crónica.

En contraste con la presentación habitual de la colecistitis crónica, el caso de referencia obedece a una presentación atípica con una vesícula gigante.

**Keywords:** giant gallbladder, chronic cholecystitis, pribram technique, atypical presentation.
found with multiple adhesions to the transverse colon, stomach, duodenum and small intestine. The gallbladder was drained and 2000 mL of bile fluid were collected. Due to the presence of significant inflammation and to the impossibility to access the Calot’s triangle, we used the Pribram’s technique plus intraoperative cholangiography. The intrahepatic and extrahepatic bile ducts were dilated, without filling defects and normal passage of contrast into duodenum (Fig. 2).

The pathological examination report of the surgical specimen described a reddish-brown mucosa with irregular cobble-stone appearance, opaque serosa, thickened wall (1.5 cm), with edema and congestion, hemorrhage and areas of necrosis, intense inflammatory and mixed infiltrate suggestive of acute exacerbation of chronic cholecystitis.

The postoperative course was favorable and the patient was discharged on postoperative day seven. After reviewing the literature, we have not yet found a single definition of giant gallbladder; however, some authors define it as an extreme enlargement of the organ with a volume exceeding 1.5 L. The cases reported of giant gallbladder were mostly associated with malignant neoplasms, bile duct obstruction or both. These conditions were ruled out in our patient by CT scan and MRCP; finally, pathological examination made the diagnosis of acute exacerbation of chronic cholecystitis.

The multiple adhesions to colon, small intestine, stomach and duodenum found during surgery were partially released, but as the Calot’ triangle could not be adequately accessed, the Pribram’s technique was used to resect the gallbladder in order to reduce the risk of intraoperative complications.

Giant gallbladder is a rare condition, with scarce bibliographic references, lack of uniform definition and epidemiological data that can be associated with congenital and acquired conditions. This case report is an atypical presentation of chronic cholecystitis.

References