

# **Gallbladder polyp with endoscopic polypectomy through cholecystogastrostomy**

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A 59-years-old man with a history of renal stones presented with heartburn symptoms for several months. He also stated that he had received abdominal operation due to cholecystitis thirty years ago. A diverticulum approximately 7 cm in diameter with narrow orifice (Figure 1, arrow) and a polypoid mass lesion (3 cm × 3 cm) (Figure 2) were found at antrum during upper GI endoscopy. An abdominal computed tomography showed the gastric diverticulum (arrow) and a large stone (star) impacted in the distal common bile duct (CBD) without intrahepatic bile duct dilatation (Figures 3). The stone of CBD was removed by endoscopic retrograde cholangiography (ERCP). He received twice partial polypectomy and the histology revealed hyperplastic polyp. At second endoscopy, we saw a small hole in the diverticulum. We injected contrast medium into the small hole under fluoroscopy. The contrast medium went through the cystic duct to common bile duct (Figure 4, arrow). The cholecystogastrostomy was made and explained the huge CBD stone impaction without biliary dilatation.

Polypoid lesions of the gallbladder can be divided into benign and malignant lesions. Benign polypoid lesions are divided into tumors or pseudotumors. Pseudotumors include polyps, hyperplasia, or other inflammatory lesions. The incidence of benign tumors of resected gallbladders ranges from 0.15% to 8.5%<sup>1</sup>. Our case is hyperplastic polyp. Laparoscopic cholecystectomy is advised for polyp larger than 10 mm, or rapid growth. To our knowledge, this is first report of gall bladder polyp with endoscopic polypectomy through cholecystogastrostomy.

The cholecystoenterostomy is a rare complication in gallstone disease and was found in 3-5% in patient with cholelithiasis. It often involves the duodenum (71%), the stomach (14%) and the colon (6%).

Gastric diverticula are usually asymptomatic with a prevalence range of 0.01% in autopsy and 0.3% in radiologic study. Diverticula can be divided into two groups: true (congenital) and pseudo (acquired)<sup>2</sup>. The true diverticula are usually located on the posterior wall of the stomach below the gastroesophageal junction; and the false diverticula are located frequently in the gastric antrum<sup>3</sup>. The acquired diverticula are further subdivided into two groups: pulsation type that associated with pyloric obstruction or severe vomiting and the traction type that frequently associated with perigastric adhesions related to inflammations of pancreas, gallbladder or spleen<sup>3</sup>. The diverticulum of the case we presented here was in the antrum and was related to

cholecystogastric fistula. It may be related to previous episode of cholecystitis and abdominal operation that the procedure was unknown. Due to the patient presented without epigastric distress, he is receiving regular follow-up at the outpatient department.

## References

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