Case report of a duplicated cystic duct: A unique challenge for the laparoscopic surgeon

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Case report of a duplicated cystic duct: A unique challenge for the laparoscopic surgeon

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A B S T R A C T

INTRODUCTION: Anatomical variants of the extrahepatic biliary tree are numerous, adding significantly to the risk of bile duct injury during cholecystectomy, especially when laparoscopic approach is employed. Duplicated cystic ducts draining a single gallbladder are extremely rare.

PRESENTATION OF CASE: A 34-year-old female presented with signs and symptoms of acute cholecystitis which was confirmed on imaging. She was found to have an accessory cystic duct on laparoscopic cholecystectomy requiring conversion to open laparotomy with intraoperative cholangiogram to delineate the anatomy.

DISCUSSION: In the English literature, there has been 20 reported cases of double cystic duct with a single gallbladder. Most of these cases were diagnosed intraoperatively despite the completion of a preoperative endoscopic retrograde cholangiopancreatography in a few of these patients.

CONCLUSION: The limited success of preoperative biliary tract imaging in demonstrating anatomical aberrances prior to cholecystectomy clearly highlights the importance of maintaining constant vigilance for even the slightest anatomic abnormality at operation. Any uncertainty or concern for ductal injury mandates immediate operative cholangiogram with cannulation of all structures in question.

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1. Introduction

Biliary tree anomalies have been detected in up to 47% of the population based on operative, cholangiographic and autopsy studies [1]. The basis of bile duct injury is failure to identify biliary anatomy especially in the cases aberrancies. Thus, identification of these anomalies in biliary anatomy is crucial to avoid the morbidity and mortality associated with bile duct injuries. Unlike the more common variant in which two cystic ducts drain two distinct gallbladders or cavities [2], duplicated cystic ducts draining a single, unilocular gallbladder is extraordinarily rare, with fewer than 20 cases reported in the English literature. We report our experience with laparoscopic cholecystectomy in the setting of double cystic ducts identified intraoperatively. The case report has been reported in line with the surgical case report (SCARE) criteria [3].

2. Presentation of case

We report a case of a 34-year-old female who presented to the emergency department with three days of constant right upper quadrant and epigastric abdominal pain with associated nausea. The patient had similar pain two months ago that resolved and did not seek medical attention. On presentation she had normal vital signs. Physical examination demonstrated right upper quadrant tenderness without peritoneal signs with negative clinical Murphy’s sign. Her blood work revealed a white blood cell count of 13,500 /microliter, alanine aminotransferase of 318 U/L, aspartate aminotransferase of 259 U/L, alkaline phosphatase of 120 U/L, and total bilirubin of 1.7 mg/dL. Ultrasonography demonstrated new mild gallbladder wall thickening and negative sonographic Murphy’s sign with equivocal suggestions of acute cholecystitis. Hepatobiliary iminodiacetic acid scan was subsequently performed and showed non-visualization of the gallbladder consistent with acute cholecystitis.

The patient was taken to the operating room and the cystic duct and artery were dissected free from the cystic triangle laparoscopically. Both structures were secured proximally and distally and divided sharply. The gallbladder was dissected from the bed using electrocautery. Due to the contracted and intrahepatic nature of...
and transected and the gallbladder was removed. The gallbladder aspect of the ducts (Fig. 2) the second accessory duct was clipped
1981 [4]. The second accessory duct was clipped
Fig. 2) In an attempt was made to cannulate the second duct
caused with indirect CBD common bile duct well seen, no bilary
the cholangiogram was performed through the gallbladder, a retro-
the ducts entered the common bile duct, and the second accessory
the gallbladder was cannulated (Fig. 1). A transhepatic evaluation the structure appeared to be a bile duct intubation.
the gallbladder was cannulated and the second accessory duct was clipped
removal the liver was excised and the second accessory duct cannulated (Fig. 1). A transhepatic evaluation the bile duct structure appeared to be a bile duct intubation.
was evaluated and showed the two cystic ducts with distal open lumens that communicated to the gallbladder.

Postoperatively, the patient’s liver function tests normalized. Patient was discharged home on postoperative day 3 and was tolerating diet. She was seen in the surgical clinic 2 weeks postoperatively and was doing well. The pathology report showed acute on chronic cholecystitis with mucosal ulceration and cholelithiasis.

3. Discussion

Intriguing with anomalous gallbladder anatomy and associated infrahepatic biliary duct aberrancy originates as far back as 1926 with Edward Boyden’s comparative report and classification of the various congenital anomalies of the gallbladder [4]. Thirty years later, Caster and Flannery categorized cystic duct duplication into 3 types: (1) Vtype, wherein 2 cystic ducts join to form a single cystic duct that then enters the CBD, (2) Htype, in which each cystic duct independently joins the bile duct system at the CBD, right hepatic duct, left hepatic duct or common hepatic duct, and (3) trabecular type, in which one cystic duct enters the CBD while the other directly enters the liver parenchyma [5].

In the English literature, there has been 20 reported cases of multiple cystic ducts draining a single gallbladder including our reported case (Table 1) [1,2,6–21]. Females constituted 75% of the reported cases. “H” type duplication with the cystic ducts joining the biliary system at the CBD, common hepatic duct, or right hepatic duct was reported in 11 cases (55%), representing the most common configuration. The “Y” and trabecular types represent 30% and 15% of the reported cases to date, respectively.

Double cystic duct was identified intraoperatively in 16 out of the 19 patients (84%) who were operated on. Despite the completion of a preoperative endoscopic retrograde cholangiopancreatography (ERCP) in 7 patients, the cystic duct anomaly was only identified in 3 cases (43%) [1,2,8–10,12,20]. This emphasizes the importance of being aware of this anatomic variant as even with invasive preoperative testing, the accessory duct was only identified intraoperatively. Cholecystectomy was performed and completed laparoscopically in 12 cases and intraoperative cholangiogram (IOC) was performed in 8 of these cases to delineate the anatomy when a second cystic duct was encountered [8–12,14,16–21]. Three other cases required conversion to laparotomy, one of which was our case, and was due to inability to clearly define biliary anatomy laparoscopically [2,13]. One case required reoperative laparotomy due to delayed recognition of the duplicated cystic duct, resulting in bile leak [9]. An IOC and preoperative ERCP was performed in that case but did not prevent the complication of a biliary leak.

4. Conclusion

The limited success of preoperative biliary tract imaging in demonstrating anatomic aberrancies prior to cholecystectomy clearly highlights the importance of maintaining constant vigilance for even the slightest anatomic abnormality at operation. Any uncertainty or concern for ductal injury mandates immediate operative cholangiogram with cannulation of all structures in question. Although laparoscopic cholecystectomy is safe in experienced hands, a low threshold for conversion to laparotomy should be had when the anatomy cannot be deciphered.

Conflicts of interest

No conflicts of interest to be declared.

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Ethical approval

The study is exempt from ethical approval in our institution.

Consent

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Author contribution

Semeret Munie: Formal analysis; Writing – original draft.
Hassan Nasser: Writing – review & editing.
Pauline H. Go, MD: Writing – original draft.
Kelly Rosso, MD: Visualization.
Ann Woodward: Supervision.

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Ann Woodward, MD.

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