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CYSTIC ARTERY PSEUDOANEURYSM FOLLOWING SUBTOTAL CHOLECYSTECTOMY FOR MIRIZZI SYNDROME

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A 55-year-old woman underwent a retrograde endoscopic cholangiopancreatography with stent placement for jaundice caused by large, non-extractable common bile duct stones, secondary to Mirizzi syndrome with a cholecystobiliary fistula (Fig. 1A). A subtotal cholecystectomy was performed with bile duct exploration (Fig. 1B) through the fistula using cholangioscopy, with extraction of the biliary stent (Fig. 1C). She was discharged on POD 4 without complications. Two weeks later, she showed acute central abdominal pain, sweating, nausea, and vomiting. On examination, she was afebrile, hypotensive (78/53 mmHg), and tachycardic (112 bpm). Abdominal tenderness was noted around the umbilicus. Laboratory tests showed hemoglobin of 9.3 g/dL and hematocrit of 28.3%. An abdominal CT scan revealed a 6 mm cystic artery pseudoaneurysm (CAP), with blood in Morrison's and Douglas's pouches (Fig. 1D). An endovascular approach was chosen, and embolization of the CAP was performed using four coils. The pseudoaneurysm was not actively bleeding at the time of the procedure (Fig. 1E-F). Recovery was uneventful. CAP is a rare vascular complication, typically secondary to inflammation from acute cholecystitis or following surgical or endobiliary interventions. A high degree of early clinical suspicion is warranted to facilitate prompt imaging, diagnosis and timely intervention.

Figure 1 |