

# Giant GB Stone in Elderly Female: A Rare Case Report

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**Abstract:** *Giant/large gallstones have high risk of complications, and technical difficulties during surgery. Gallstones >5 cm are very rare, with higher risk of complications. Gallbladder should be removed even if asymptomatic. Gallstones >3 cm have increased risk for gallbladder cancer, biliary enteric fistula and ileus. LC has challenges that include grasping the gallbladder wall, exposure of Calot's triangle, and retrieval of gallbladder out of the abdomen. LC appears to be procedure of choice and should be performed by an experienced surgeon, considering the possibility of conversion to open cholecystectomy in case of inability to expose the anatomy or intraoperative difficulties*

**Keywords:** Giant gallstone, Large gallstone, Laparoscopic cholecystectomy, Open cholecystectomy

## 1. Introduction

Gallbladder stones are very common [1, 2]. The size of a gallstone is important, as giant/large gallstones have higher risk of complications and higher technical difficulties during laparoscopic cholecystectomy (LC) [3, 4]. Gallstones > 3 cm carry higher risk for gallbladder cancer and gallstones >5 cm are very rare with only very few cases reported in the literature [4–9]. Gallstones can present in different locations: in the gallbladder which may cause biliary colic or acute cholecystitis, in the biliary tree which may cause biliary obstruction, or in the gastrointestinal tract which may cause

## 2. Case

60 year old female presented to our opd with upper abdominal pain for 6 month a/w occasional vomiting for 3 month.

The pain was localised to epigastrium. The pain is aggravated by food intake and relieved by medication. The pain is of moderated intensity and non radiating with vomitus containing food particle. No History of fever diarrhoea, constipation.

On palpation mild tenderness was presented in right hypochondrium. The abdomen was soft with no guarding no rigidity The patients blood investigation including CBC, LFT, RFT were normal.

Patient abdominal X - ray AP erect was suggestive of 3 \* 2.5 cm opaque lesion in right hypochondrium.

USG - shows large 22 mm sized echogenic foci with posterior echoic shadowing at GB fossa region with no GB separately visualised.

CECT (abdomen & pelvis) shows particular calcified lesion of size 27\*24 mm in GB fossa region P/O benign

calcification or calcified hydatid cyst more likely than GB calculus.

MRCP - large calcification segment 5 of liver.

The patient was taken for Diagnostic laparoscopy with sos further proceeding intraoperatively a giant GB calculi measuring around 3\*2.5\*2.5 cm was found.

Laparoscopic cholecystectomy was done with single drain kept in right subdiaphragmatic space. the drain was removed on pod 5. The patient was discharged on pod 6. The patient was in regular weekly follow up for 6 month with no complications.

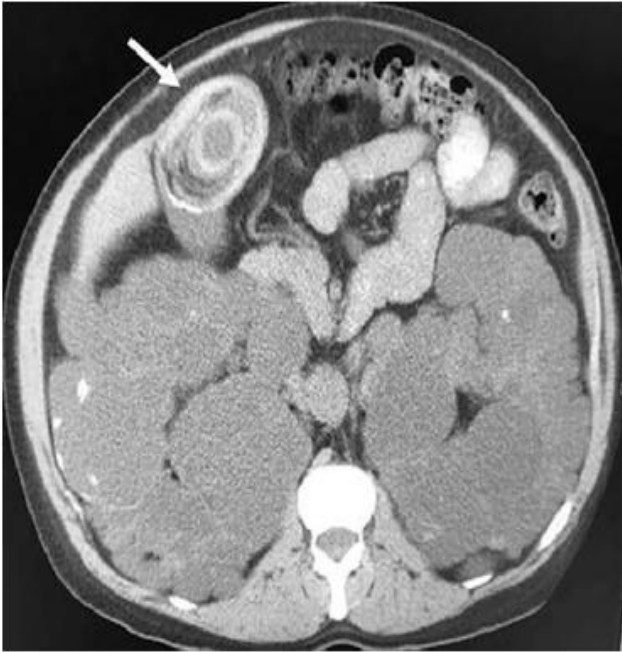


AXR (Erect AP view) showing Giant GB stone

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CECT abdomen Showing Gaint GB stone



### 3. Discussion

Cholelithiasis is one of the commonest surgical problems and is attributed to various factors including cholesterol hypersecretion, reduced excretion of bile salts and/or phospholipids bile salts, hypomotility of gallbladder, and haemolytic disorders. Gallstones larger than 5 cm are referred to as "giant gallstones" and are rare [1]. Due to the proven relationship between the greater size of gallstones with gallbladder cancer, patients with giant gallstones even when asymptomatic are recommended cholecystectomy. In addition to that, it is considered a risk factor for fistula formation with the possibility of bowel obstruction and Mirizzi syndrome [2]. And regarding the choice of surgical approach, many workers believe that a giant gallstone may be an indication for the adoption of an open approach [3] or else for conversion to open cholecystectomy from laparoscopic [4]. This is due to the difficulties that the giant stones pose during LC. First, the bigger stones usually cause inflammation which thickens the gallbladder wall. Second, a large gallstone may cause technical challenges. For instance,

it may be highly challenging to hold the gallbladder with laparoscopic tools and to obtain the proper anatomical exposure of Calot's triangle for safe dissection [7]. And towards the end of LC, at the time of the retrieval of the gallbladder specimen along with the giant stone, there is a size mismatch with the 10 - 11 mm port sites which require an extension of the incision. However, even with the giant gallstones, LC performed by a skilled laparoscopic surgeon is the best initial course of action, in the opinion of the author, unless the technical challenges or an inability to expose the anatomy led to conversion to open cholecystectomy. The author was able to conduct safe LC without any conversion even in emergency settings.

### 4. Conclusion

Giant gallstones are associated with high risk of complications and LC is warranted in symptomatic and asymptomatic patients. Even for giant gallstones, LC appears to be the primary procedure of choice over open cholecystectomy and should be performed by an expert laparoscopic surgeon, taking into consideration the possibility of conversion to open in case of inability to expose the anatomy and any intraoperative technical difficulties.

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