ACUTE OBSTRUCTIVE SUPPURATIVE CHOLANGITIS IN A MAN WITH AN ENLARGED INFERIOR PANCREATICODUODENAL LYMPHNODE

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Summary

A case report of a 55-year-old male, who was seen with epigastric pain and hyperamylasemia, is to be presented. He failed to respond to the intensive antibiotic therapy, and subsequently acute obstructive suppurative cholangitis fully developed. At laparotomy, an inflammatory enlarged inferior pancreaticoduodenal lymphnode, which apparently compressed the common bile duct, was found. To our knowledge, no prior case of acute obstructive suppurative cholangitis provoked by an enlarged lymphnode has been reported. A plea is made for attention to lymphnodes involved by inflammatory or neoplastic disorders, as well as common provoking agents such as calculi.

Key Words: cholangitis, pancreaticoduodenal lymphnode.

Introduction

In 1959 Reynolds and Dargan presented 5 cases of serious cholangitis which was provoked by impacted biliary calculi. The clinical manifestations of the syndrome, which they designated acute obstructive cholangitis, were central nervous system depression and shock in addition to Charcot's triad of chills with fever, jaundice and right upper quadrant pain. At operation the common bile duct was found to contain purulent material under pressure. They concluded that nonoperative therapy was desperate and the results of emergency surgical decompression of the biliary tract were gratifying even in the moribund patient.

The pathophysiology of this disease is characterized by infection proximal to an obstructing lesion of the biliary tract. The function of the liver, kidneys and cardiovascular system may be impaired by septicemia.

Following Reynolds and Dargan's definition of the syndrome, a large experience has been accumulated. In the previously reported cases the obstruction was commonly due to biliary calculi, but occasionally was due to common duct stricture or neoplasm in the periampullary region.

In this paper a report is made on a case of acute obstructive suppurative cholangitis with an enlarged inferior pancreaticoduodenal lymphnode which is considered to compress the common bile duct.

Case Report

A 55-year-old male was admitted because of
epigastric pain. He was well until seven years previously, when pulmonary tuberculosis was found and treated for two years. He drank alcoholic beverages in modest amounts. Two months before entry the patient first experienced transient epigastric discomfort after meal. Ten days later severe epigastric pain, retching and temperature raise developed. He was admitted to another hospital. The white cell count was 13,200 per mm³, and the serum amylase was 1,068 units per ml. The diagnosis of acute pancreatitis was made. He was successfully treated with cefalothin, and discharged on the 26th hospital day. He relapsed soon, however, and entered our hospital.

On admission the temperature was 36°C, the pulse 84, the blood pressure 100/66. Icterus was noted, but he was relatively well. There was epigastric tenderness and a palpable enlarged non-tender liver with the edge 2 cm below the costal margin.

Laboratory data were as follows; hematocrit, 34.7 per cent; WBC, 5,100 per mm³; erythrocyte sedimentation rate, 28 mm per hour; serum amylase (normal, 160 or below), 343 units per dl; total bilirubin, 6.3 mg per dl; direct bilirubin 3.4 mg per dl; GOT, 248 mU per ml; GPT, 222 mU per ml; alkaline phosphatase (normal, 25 to 85), 472 mU per ml; cholesterol, 284 mg per dl; fasting blood glucose, 113 mg per dl. The plain abdominal film was negative. The hypotonic duodenogram demonstrated a “double- contour” along medial aspect of the descending duodenum (Fig. 1). Ultrasonic examination for stones was negative.

On the 16th hospital day the temperature rose to 37.3°C, and the serum amylase was elevated to 577 units per dl. Neither hetacillin nor cefalothin by vein had effect. The temperature rose to 39.9°C, the serum bilirubin was elevated to 18.7 mg per dl, and the patient complained of increasing abdominal pain and retching. On the 24th hospital day the blood pressure dropped to 60/40, and severe hypotension persisted for three days running. Nevertheless, mental confusion was absent.

On the 43rd hospital day, operation was undertaken. The common bile duct and the gallbladder were found to be markedly dilated and acutely inflamed. The liver had multiple abscesses. Upon palpation, the pancreas was firm in consistency and there was a 3 cm inferior pancreaticoduodenal lymphnode. When the common bile duct was incised, spurted the frankly purulent material. The operative cholangiogram showed no stones. After the distal common bile duct was found patient, a T-tube was inserted. Bile from the common duct cultured Klebsiella. Surgery resulted in dramatic improvement. The temperature was normal shortly after the operation, and the serum bilirubin value slowly decreased. The T-tube was removed two months postoperatively.