Is This Phantom Pain?

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Abstract Right upper quadrant abdominal pain may be due to many causes, and at times may give rise to diagnostic dilemma. We present here a young lady with biliary type of pain who was eventually found to have gall bladder agenesis with aerobilia, in the absence of prior biliary intervention.

Keywords Gall bladder · Agenesis · Biliary pain

A 36-year-old lady presented to the emergency department with a 2-days history of colicky upper abdominal pain followed by nausea and 2 bouts of bilious vomiting. The pain was dull aching with radiation to the RUQ and there were no aggravating or relieving factors. She had a long history of dyspepsia. She did not have any previous surgery or endoscopic intervention. On clinical examination, the patient was afebrile and vitals were stable. There was severe tenderness over the right hypochondrium. Rest of the systemic examination was normal. A provisional clinical diagnosis of acute cholecystitis was made.

Routine blood tests including normal complete blood count, ESR, total bilirubin, aspartate aminotransferase, alanine aminotransferase, alkaline phosphatase, lipase and amylase were within normal limits. A transabdominal ultrasound was performed that failed to localize the gall bladder (GB). The common bile duct (CBD) appeared

otherwise normal except for aerobilia. This was followed by a abdominal CT scan (Fig. 1) showing aerobilia in the hepatic hilum. There was no evidence of pancreatitis. We then performed an MRCP (Fig. 2) that showed an absence of the gall bladder with a rudiment of the cystic duct. The CBD and the intrahepatic biliary radicals appeared normal. This patient was further evaluated with esophagogastroduodenoscopy and barium studies, that came out to be normal. We did not perform an endoscopic ultrasonography (EUS). She was managed conservatively and her symptoms resolved spontaneously within 2 days.

Agenesis of the gall GB is a rare condition with a reported incidence of less than one in 6,000 live births [1]. This may be asymptomatic, associated with multiple fetal anomalies or may present with gastrointestinal symptoms including pain [2, 3]. Majority of the patients who have symptoms usually present with RUQ pain (90.1 %) and

Fig. 1 Abdominal CT scan showing aerobilia at the hepatic hilum

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Fig. 2 MRCP showing absence of the gall bladder with a cystic duct remnant

one possible etiology has been found to be choledocholithiasis. Our patient did not have any definite radiological or

biochemical evidence of choledocholithiasis. However, presence of aerobilia in the absence of a history of prior ERCP or other surgical intervention may suggest passage of a small CBD stone or microliths through the ampulla, thereby leading to her self-limiting biliary pain. The other possibility that might be considered under the given circumstances is sphincter of Oddi dysfunction (SOD). However, since the patient did not fulfill the classical criteria for Type 1 or 2 SOD, we did not consider it safe to subject her to a sphincter of Oddi manometry or any biliary intervention at this time. However, it will be important to keep the patient on a long term follow-up and investigate her further in the event of relapse of similar symptoms.

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