calculi, treatment by ERCP can be considered in reference centres (as in our case), since this has a lower morbidity and mortality rate than surgery.[10]

Conflict of interest

The authors declare that they have no conflict of interests.

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A strange finding in the common bile duct

Un hallazgo extraño en el conducto biliar común

This is a 75-year-old woman with a past surgical history of laparoscopic cholecystectomy in 2011. In 2013 she presented with an episode of acute cholangitis. An endoscopic retrograde cholangiography (ERCP) with sphincterotomy was performed. Biliary stones were removed and a plastic-metal stent was placed. The stent was removed 3 months later.

The patient presented to our department with recurrent biliary pain in the past few months. Complete blood counts and liver function tests were normal. An abdominal ultrasound showed a mild dilation of the common bile duct (CBD) measuring up to 11 mm and a 20 mm hiperechogenic linear image within the CBD. An ERCP was performed and confirmed a dilated CBD with a 20 mm long linear filling defect (Fig. 1). Biliary sphincterotomy was extended and a balloon sweep revealed biliary sludge and exteriorization of an odd-looking and elongated foreign body (Fig. 2), which proved to be a surgical clip (Hem-o-Lok®clip – Teleflex-USA) (Fig. 3).

Surgical clip migration following cholecystectomy is a rare but well-documented complication. The timeframe between the initial cholecystectomy and development of complications can be variable with case reports describing migration after as much as 14 years.[1] The exact mechanism of clip migration and stone formation remains unclear. Some authors suggest that clips can cause erosion and

Figure 1 Dilated common bile duct with a 20 mm long linear filling defect.

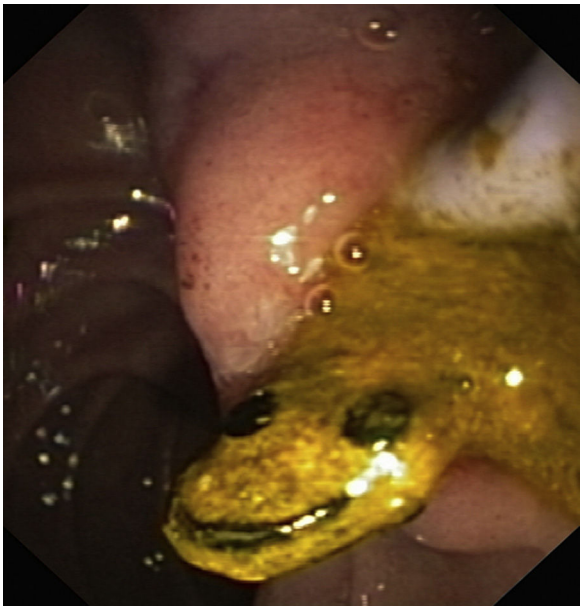

Figure 2 A odd-looking and elongated foreign body removed from the common bile duct.

Figure 3 Surgical clip (Hem-o-Lok®clip – Teleflex-USA).

necrosis of the wall of the CBD leading to migration of the clip. Predisposing factors for clip migration include a short cystic duct stump, inappropriate placement of clips and local infection or suppurative complications around the CBD.[2] In most reported cases, the migrated surgical clip acts as a nidus for choledocholithiasis and subsequent biliary obstruction. However, surgical clips alone can also cause symptoms, with few cases previously reported.[3] The diagnosis may be suspected based on noninvasive imaging, such as X-ray, ultrasound, CT scan, and MRCP. Abdominal ultrasound is not the best imaging modality to identify surgical clips because clips can mimic biliary stones. Although CT and MRCP can detect clips and their relation to the lithiasis, ERCP is the preferred test because it can simultaneously remove the calculi and the clip[4] with a high rate of success.[5] Endoclip migration could be potentially avoided by the use of absorbable endoclips, or alternatively ultrasonic dissection without clipping.[6]

The authors emphasize the rarity of the case and the importance of the differential diagnosis of post-cholecystectomy recurrent choledocholithiasis or abdominal pain.

Conflicts of interest

The authors declare no conflicts of interest.

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