

**GALL STONE DISEASE AND  
RELATED DISORDERS-  
COMPLETE CURE WITH  
HOMOEOPATHY**

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# GALL STONE DISEASE AND RELATED DISORDERS- COMPLETE CURE WITH HOMOEOPATHY

## KEYWORDS

Cholelithiasis, Cholecystitis, Gall Stones, Homoeopathy, Jaundice, Sludge, Biliary, Bile, Cholangitis

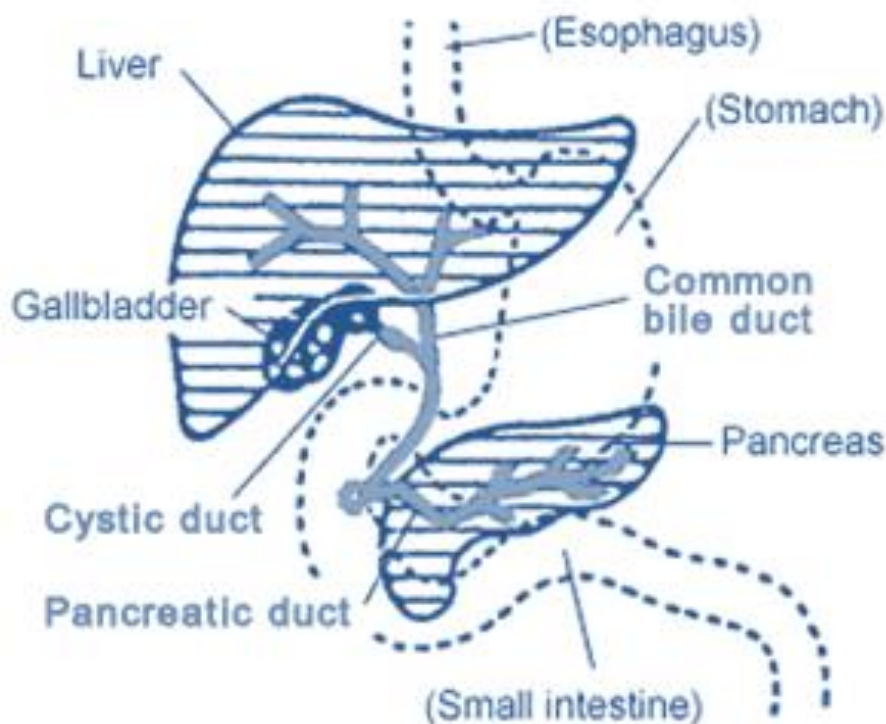
## ABSTRACT

Gall bladder disease includes inflammation of gall bladder (Cholecystitis), inflammation of CBD (Cholangitis), gall bladder sludge, gall bladder stones (Cholelithiasis), CBD stone (choledocolithiasis) and so many. The symptoms of the underlying pathology differ from each other. Local and systemic signs and symptoms are the key to find the exact similimum of the remedy. Here we are discussing a case of gall bladder sludge with multiple calculi disappearing completely after proper homoeopathic treatment.

## STRUCTURE OF THE BILIARY SYSTEM

- Right and left hepatic ducts- CHD at 3- 4 cm, outside the liver
- Cystic duct joins CHD- CBD
- CBD- 4-5 cm. length, passes down behind the duodenum, near the head of the pancreas
- CBD- drains via the ampulla of Vater- D2
- Gall bladder lies in a depression in the undersurface of the right hepatic lobe
- CBD- 6 mm. in diameter
- Bile made by the liver, passes down the biliary tract into the GB- stored, concentrated- active reabsorption of water

### Biliary Tract



## FUNCTION OF THE BILIARY SYSTEM

- Lipid-rich food- duodenum promotes secretion of CCK- contraction of the GB forcing bile into the duodenum
- Bile- emulsifying agent, facilitates hydrolysis of lipids by pancreatic lipases.
- If bile fails to reach duodenum (biliary tract obstruction), lipids are neither digested or absorbed resulting in the passage of loose foul-smelling fatty stools (steatorrhea)
- Fat-soluble vitamins (A, D, E, and K) not absorbed
- Lack of vitamin K- inadequate prothrombin synthesis and hence defective clotting- problems if surgery is necessary

## PATHOGENESIS OF GALLSTONE DISEASE

### INCIDENCE

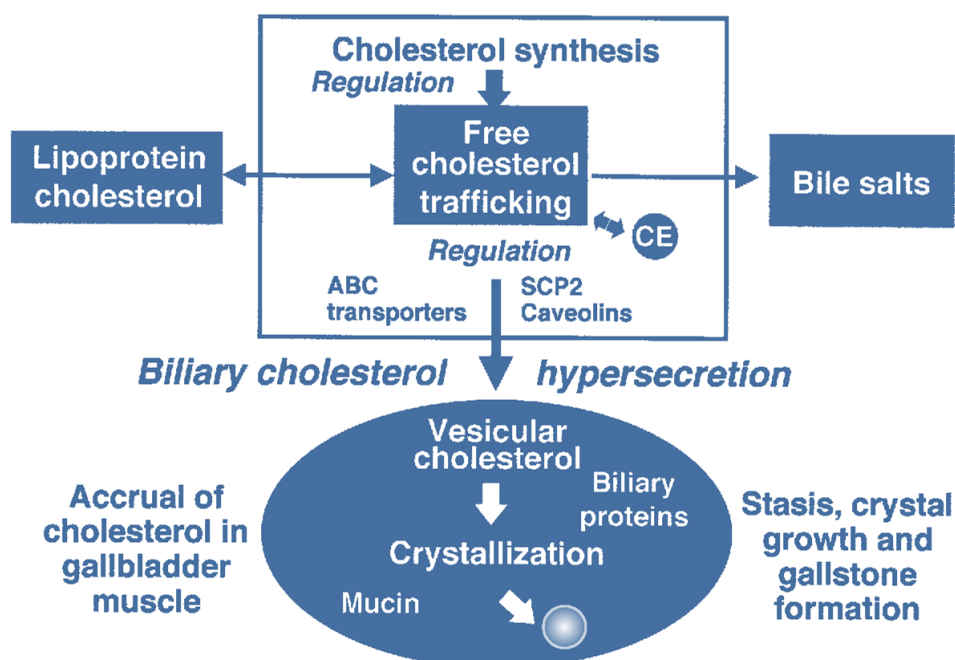
- Most gallstones- cholesterol+bile pigment+calcium salts
- Small proportion are “pure” cholesterol stones
- Asia- most gallstones-bile pigment alone

### PATHOPHYSIOLOGY

- Mixed stones- combination of abnormalities of bile constituents, bile stasis and infection
- Pigment stones- excess bilirubin secretion due to hemolytic disorders and infection

### MAIN FACTORS

- Change in concentration of bile constituents
- Biliary stasis
- Infection
- Bile salts and lecithin- maintain cholesterol in a stable micelle formation
- An excess of cholesterol in relation to bile salts and lecithin is one of the main factors
- Cholesterol precipitation is enhanced by biliary stasis and infection



## EPIDEMIOLOGY OF GALLSTONES

- 10% of the adult population probably have gallstones
- Women are affected 4 times as often as men
- Pregnancy, obesity, diabetes are predisposing factors
- The typical patient is said to be: fair, fat, fertile, female of forty
- Poor fiber diet may play a part

## INVESTIGATIONS

- Exclude hematological and liver abnormalities
- Establish whether gall stones are present in the GB or CBD
- Assess integrity of bile duct and pancreatic duct
- Hemolytic disorders: hereditary spherocytosis, thalassemia and sickle cell disease- pigment stones
- Liver function tests- jaundice
- Blood cultures- in cases of severe angiocholitis
- Endoscopy for patients with frequent vomiting or diarrhea
- Ultrasound scan
- CT- Abdomen
- Plain Abdomen X RAY

## NON-JAUNDICED PATIENTS

- Not necessary preoperative investigations for duct stones
- If in doubt- preoperative cholangiography at cholecystectomy
- Cholangiography via cystic duct into the CBD- filling defects caused by stones or distortion of the lower end of the CBD or obstruction

## JAUNDICED PATIENTS

- History of transient jaundice- ERCP or cholangio- nuclear magnetic resonance scan
- Frank obstructive jaundice- stone and/or cephalic pancreatic tumor

## OBSTRUCTIVE JAUNDICE

### BIOCHEMICAL FEATURES OF OBSTRUCTIVE JAUNDICE

- Conjugated hyperbilirubinemia
- Elevation of alkaline phosphatase
- Minimal or no elevation of the serum transaminases
- Presence of the bilirubin in the urine as the conjugated bilirubin is water soluble
- Elevation in the serum of cholesterol and bile acid levels
- Ultrasound scan of the abdomen: dilatation of the biliary ducts, stone lodged in the duct, cephalic pancreatic nodule, enlarged lymph nodes in the porta hepatis
- ERCP- diagnostic and therapeutic procedure- endoscopic sphincterotomy releasing the stone, relieving the jaundice
- Percutaneous trans-hepatic cholangiography

## CHRONIC CHOLECYSTITIS

- Intermittent cystic duct obstruction

- Typically, patients are overweight female
- Chronic inflammation- thickened and shrunken GB
- Long history of RH pain, nausea, vomiting
- Pain exacerbated by fatty meals
- Symptoms are ill-defined: pain, nausea, fatty food intolerance
- Signs: mild RH tenderness
- Differential diagnosis
  - Peptic ulcer disease
  - Urinary tract infection
  - Irritable bowel disease

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#### CHRONIC CHOLECYSTITIS MANAGEMENT

- Cholecystectomy is the definitive treatment
- Classic or laparoscopic

#### BILIARY COLIC

- Sudden and complete obstruction of the cystic duct by stone
- Severe pain, the patient twists in agony until the pain resolves
- A bout of vomiting often precedes the end of the attack
- History of previous similar episodes
- Few positive physical findings- local tenderness, no fever

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#### BILIARY COLIC MANAGEMENT

- Pain relief, USS of the abdomen
- Immediate cholecystectomy or put the patient on the waiting list
- Avoid fatty foods

#### ACUTE CHOLECYSTITIS

- Surgical emergency
- Biliary colic, fever, tachycardia
- RH tenderness
- Palpable RH inflammatory mass
- Clinical course of acute cholecystitis is more prolonged than biliary colic

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#### ACUTE CHOLECYSTITIS MANAGEMENT

- Ultrasonography, CT: thickened wall
- Oral intake restricted to fluids
- IV fluids, pain killers and antibiotics
- Early cholecystectomy
- For inflammatory mass- conservative treatment- elective cholecystectomy after 2-3 months

#### GANGRENOUS CHOLECYSTITIS

- Empyema of the gall bladder
- GB distended with pus- an abscess of the GB
- Part of the GB wall becomes necrotic- perforation- biliary peritonitis

- Perforation is usually walled off by omentum- localized abscess formation
- Sometimes- subphrenic abscess or generalized peritonitis
- Surgery without delay

#### GALLSTONE ILEUS

- Uncommon complication of chronic cholecystitis
- GB becomes adherent to the duodenum, a stone ulcerating through the wall to form a fistula
- Fistula decompresses the obstructed GB and allows stones to pass into the bowel and gas to enter the biliary tree
- Diagnosis- plain abdomen X ray- gas into the biliary tree or fluid levels of the small bowel- biliary ileus
- If obstructing stone is radio-opaque can be seen as an opacity in the RIF
- Operation is needed to remove the obstructing stone from the terminal ileum: enterotomy, extraction, enteroraphy

#### BILIARY ILEUS

- Rigler's triad of findings: small bowel obstruction; pneumobilia; and gallstone in right iliac fossa.

#### BILE DUCT STONES

- Nearly always originated in the GB and passed through the cystic duct
- Most stones are small enough to pass out of the biliary system into the duodenum, resulting in biliary colic and transient jaundice
- CBD is narrowest at its lower end and stones too large to pass out
- They tend to lodge at this point
- A stone here either becomes impacted- progressive jaundice or acts as a ball-valve- intermittent jaundice
- Obstruction results in gradual dilatation of the biliary tree
- If dilatation is long standing it does not regress even after removal of the obstruction- bile stasis- further stone formation
- Note that GB does not distend when there is an inflammatory fibrosis caused by gall stones

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#### CLINICAL PRESENTATION OF BILE DUCT STONES

- Obstructive jaundice
- Asymptomatic duct stones
- Acute pancreatitis
- Ascending cholangitis

#### OBSTRUCTIVE JAUNDICE

- Stones in the CBD
- Carcinoma of the head of the pancreas
- Periampullary tumors
- Benign strictures of the CBD
- Extrinsic bile duct obstruction
- Intrahepatic bile duct obstruction

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#### ASYMPTOMATIC DUCT STONES

- Any patient with gall stones may have duct stones
- Some surgeons do at cholecystectomy, routine cholangiography to exclude the presence of CBD stones
- Some surgeons do that if there are positive test of cholestasis or dilated CBD
- Common bile duct stone (choledocholithiasis)-The sensitivity of transabdominal ultrasonography for choledocholithiasis is approximately 75% in the presence of dilated ducts and 50% for nondilated ducts

#### ACUTE PANCREATITIS

- Stones near the ampulla of Vater may interfere with drainage of pancreatic enzymes onto the duodenum
- This induces bile reflux into the Virsung duct- acute pancreatitis

#### ASCENDING CHOLANGITIS

- Bile stasis in the CBD due to chronic duct obstruction- predisposes to bacterial infection
- The infection extends proximally to involve the intrahepatic duct system
- Pain, swinging pyrexia, jaundice
- Life-threatening condition- acute supportive cholangitis
- Urgent bile duct drainage: surgery or endoscopic sphincterotomy

#### CARCINOMA OF THE GALL BLADDER

- Chronic irritation by stones over a long period is believed to predispose to adenocarcinoma of the gall bladder
- Rare condition, found in the elderly
- Usually unexpected finding at cholecystectomy, incurable at the time of detection
- Presenting symptoms similar to chronic inflammatory gall bladder disease
- Jaundice may develop

#### MANAGEMENT OF GALLSTONE DISEASE

- Non-surgical treatment
- Surgical treatment

#### NON-SURGICAL TREATMENT

- Chenodeoxycholic acid increases the bile salt pool and inhibits hepatic cholesterol secretion
- Long-term treatment- slow dissolution of cholesterol stones
- High-rate of stone recurrence
- Side-effects- diarrhea and hepatic damage

#### SURGICAL TREATMENT

- Open or laparoscopic cholecystectomy
- Exploration of CBD- preoperative cholangiography
- Presence of CBD stone- stone extraction- T tube drainage (Kehr)
- T-tube cholangiography after removal at 14-21 days postoperatively

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#### BILE DUCT DRAINAGE PROCEDURES

- Choledoco-duodenostomy
- Choledoco-jejunostomy
- Trans-duodenal sphincteroplasty
- Endoscopic sphincterotomy

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#### COMPLICATIONS OF BILIARY SURGERY

- Retained stone in the CBD- endoscopic sphincterotomy
- Biliary peritonitis due to bile leakage- lavage and drainage
- Bile duct damage- relaparotomy- reconstruction
- Hemorrhage- slipping knot from the stump of the cystic artery- hemostasis
- Ascending cholangitis- late complication of choledocoduodenostomy

#### A CASE OF GALL BLADDER DISEASE

Km. Y..... F 20 years, having severe colicky pains upper abdomen, off and on for last three months, accompanied by retching, vomiting, persistent nausea, anorexia and weight loss was brought to our OPD.

O/E- BP 100/62 mmHg, RR 16/M, HR 78/m, SpO2 98%, S1S2 Normal, Abdomen tender, bloated, Pallor++, Icterus++, tongue yellowish coated at base.

Physical generals- Lean, thin, anemic, chilly patient, general aggravation of complaints in morning, worse breakfast after. Desire salt++, aversion fats. Prefers lying on abdomen. Much weakness. Profuse sweats. Constipation, hard stools. Sometimes diarrhoea with extreme thirst.

Mental generals- Mild, gentle, anxious, fearful. Anxiety attacks with shortness of breath.

Rare peculiar- Lying on abdomen relieves her burning pains in abdomen.

#### INVESTIGATIONS

- USG abdomen- 24-02-2023- Echogenic material with tiny echogenic foci with faint shadowing in GB likely lithogenic sludge/tiny calculi embedded within sludge.
- CBC- HB 7.9, TC-11200, N 72, L 23, E 04, M01, B0, ESR 28, MCV 90, PCV 33, MCH 27.9, MCHC 31.5, Platelet count 3.9, RBC count 3.7
- KFT- BUN 36, S. Cr. 1.2, S. Uric acid 4.9, Calcium 8.8, Total Protein 6.8, Albumin 4.1, Globulin 2.7, A:G Ratio 1.5
- LFT- Total Bilirubin 2.9, Direct 1.5, Indirect 1.4, ALP 198, SGPT 340, SGOT 248
- Viral Markers- Negative for HIV, HCV and HBsAg
- USG abdomen- 30-05-2023- Ultrasound whole abdomen reveals normal study.
- CBC- HB 10.1, TC-10100, N 71, L 21, E 05, M01, B0, ESR 228, MCV 88, PCV 34, MCH 28.3, MCHC 31.85, Platelet count 3.5, RBC count 3.9
- KFT- BUN 37, S. Cr. 1.1, S. Uric acid 4.3, Calcium 8.9, Total Protein 6.3, Albumin 4.0, Globulin 2.3, A:G Ratio 1.7
- LFT- Total Bilirubin 1.1, Direct 0.5, Indirect 0.6, ALP 87, SGPT 40, SGOT 47

## AYUSH DIAGNOSTIC CENTRE

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**Dr. D.N. Gangwar**  
MBBS,MD(RADIO-DIAGNOSIS)

Date: 24.02.2023	Srl No.:	Reporting Date: 24.02.2023
Name: Miss. Yashvi		Age/Sex: 20 YRS/F
Ref By: Self		

**ULTRA SOUND SCAN OF WHOLE ABDOMEN**

**Liver** is of normal size. Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. PV and hepatic veins are not dilated.

**Gall bladder** is of normal size. Wall is not thickened. Echogenic material with tiny echogenic foci of size 1-2 mm with faint shadowing seen in GB likely ? lithogenic sludge/? tiny calculi embedded within sludge.

**Common bile duct** is not dilated. No calculus is seen in visualised CBD.

**Pancreas** is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

**Spleen** is of normal size and shape. Echotexture is normal. No focal lesion is seen.

**Kidneys** are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen.  
RK 94x49 mm & LK 92x44 mm  
Collecting system does not show any dilatation or calculus either side.

**B/L ureters** are not dilated.

No enlarged nodes are visualised. No retro-peritoneal lesion is identified. Great vessels appear normal.

**Urinary bladder** is well distended, normal wall thickness, smooth in outline & does not show any calculus or mass lesion. Post void residual urine is nil.

**Uterus** is anteverted and measure 67x39x29 mms. Myometrium shows normal echo-pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 4 mms.

**Both ovaries** are visualized and normal size and echotexture. Right ovary measures 19x10mm. Left ovary measures 20x11mm.

No free fluid is seen in pouch of Douglas. B/L pleural space are clear. Tenderness present epigastrium, possibility of gastritis.

**IMPRESSION :** ECHOGENIC MATERIAL WITH TINY ECHOGENIC FOCI WITH FAINT SHADOWING IN GB LIKELY ? LITHOGENIC SLUDGE/? TINY CALCULI EMBEDDED WITHIN SLUDGE.  
ADV- HEMOGRAM, LFT & REPEAT USG UPPER ABDOMEN AFTER 2 WEEKS.  
Please correlate clinically

**Dr. D.N. Gangwar**  
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Consultant Radiologist

## IMAGE DIAGNOSTICS & CT & MRI CENTRE

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Name	Ms. YASHVI	Date	30/05/2023
Ref. By	RAJNEESH KUMAR SHARMA	Age / Sex	21 Yrs. Female

**USG WHOLE ABDOMEN**

Liver is normal in size measuring 130.9mm in size and shows normal echotexture and smooth outline. No focal space occupying lesion is seen in parenchyma. Portal vein is normal in size.

**IHBR** are not dilated. **CBD** is normal in caliber.

**Gall bladder** is distended and shows echo free lumen. GB wall thickness is normal. No pericholecystic fluid is noted.

**Visualised pancreas** is normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

**MPD** is not dilated.

**Spleen** is normal in size measuring 67.6mm with normal shape and echotexture. Splenic vein is normal in size with normal color flow. No focal lesion is seen within the splenic parenchyma.

**Right kidney** normal in size (85.6x35.4mm), shape and echotexture. Cortico-medullary differentiation is normal. No focal lesion is seen. No evidence of dilatation / calculus seen within the pelvicalyceal system.

**Left kidney** is normal in size (93.2x42.7mm), shape and echotexture. Cortico-medullary differentiation is normal. No focal lesion is seen. No evidence of dilatation / calculus seen within the pelvicalyceal system.

**Urinary bladder** is distended and shows normal wall. No obvious intraluminal filling defect is noted.

**Uterus** is normal in size with normal echotexture. No focal lesion is seen within uterine parenchyma. Endometrial thickness measures 9.6mm. **Cervix** appears normal.

**Bilateral ovaries** are normal in size, morphology and echogenicity.

**Bilateral adnexae** are normal. No free fluid is noted in pouch of Douglas.

No free fluid is noted in abdomen. No significant mesenteric/retroperitoneal lymphadenopathy is noted.

Bowel loops appear grossly normal. No obvious bowel wall thickening is noted.

**IMPRESSION :** Ultrasound whole abdomen reveals normal study.  
**Adv.:-** Clinical correlation

**Dr. SHANTANU SINGH CHAUHAN**  
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Consultant Radiologist

This is a professional opinion and not a final diagnosis. All investigations have some limitations and errors represented here are based on imaging features noted during examination. For further confirmation of diagnosis and clinical-pathological investigations further imaging and non-imaging investigations like MRI, PET-CT, TUS USG, Doppler, endoscopy etc. will be required. The examination and several studies are already suggested if imaging findings do not correlate with clinical findings and for surgical patients. Please ask for a correction. If you notice any typing errors in this report, your feedback will be appreciated.

**Facilities**  
• एम.आर.आई (MRI) • सी.टी. स्कैन (4 Slice CT Scan) • डिजिटल एक्स-रे (Digital X-Ray) • यूलट्रासाउंड (Ultrasonography) • पैथोलॉजी (Pathology)  
• एंगิโอप्लास्टी (2D, 4D, Color Doppler, TUS, TMS), Anomaly Scan, Fetal ECG • High Frequency Imaging (Phlebotomy, Neck, MSK Etc.) • USG Guided Intervention (FNC, Biopsy, Tapping Etc.)  
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• सभी प्रकार की ऑर्गेन की बिना किसी भी दर्द के प्रत्यक्ष प्रत्यक्ष है • अनुसंधान प्रयोगशाला द्वारा ऑर्गेन की प्रत्यक्ष प्रत्यक्ष है • Not valid for medical legal purposes

## CASE ANALYSIS

- GENERALS - LEAN PEOPLE
- GENERALS - ANEMIA
- GENERALS - HEAT - lack of vital heat
- GENERALS - MORNING
- GENERALS - BREAKFAST - after - agg.
- GENERALS - FOOD AND DRINKS - salt - desire
- GENERALS - FOOD AND DRINKS - fat - aversion
- SLEEP - POSITION - abdomen, on
- GENERALS - WEAKNESS
- PERSPIRATION - PROFUSE
- RECTUM - CONSTIPATION
- STOOL - HARD
- STOMACH - THIRST - diarrhea, with
- MIND - MILDNESS
- MIND - ANXIETY
- MIND - FEAR
- MIND - ANXIETY - respiration; with impeded
- **ABDOMEN - PAIN - lying - abdomen; on - amel. – burning** (Rare peculiar symptom)

## PRESCRIPTION

Though Arsenicum album seems to be the most similar remedy, Acetic acid covers the rare peculiar symptom- ABDOMEN - PAIN - lying - abdomen; on - amel. – burning, which is only available in this remedy.

This is an absolutely specific symptom of Acetic acid. On this basis, Acetic acid 0/15 potency, one dose daily night, was prescribed for three months, as the patient was from a distant place and could not visit frequently.

The miracle happened with complete vanishing of functional as well as pathological symptoms with use of Homoeopathic remedy- Acetic acid 0/15, HS for three months.

## CONCLUSION

Homoeopathy is always infallible if used as per principles laid down in Organon of medicine by Master Hahnemann. In this case, closer remedy was Arsenicum album, but the rare peculiar and absolutely specific symptom was used to find the perfect similimum with cure. These special symptoms are of great value and always the true guiding key to the successful prescribing.

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Endoscopic Retrograde Cholangiopancreatography (ERCP) > 2. Cholelithiasis with Choledocholithiasis Book: Greenberger's CURRENT Diagnosis & Treatment Gastroenterology, Hepatology, & Endoscopy, 4e ...2. Cholelithiasis with Choledocholithiasis When patients present with the combined problem of gallstones in the

gallbladder and bile duct simultaneously, there are two questions to answer: (1) what is the best method for clearing the bile duct and (2) what should be done with the gallbladder...



Gastrointestinal Disease > 1. Cholelithiasis Book: Pathophysiology of Disease: An Introduction to Clinical Medicine, 8e



Opus



Encyclopedia Homoeopathica



Pathology of the Liver, Gallbladder, and Extrahepatic Biliary Tract > Cholelithiasis Book: Pathology: A Modern Case Study, 2e ...Cholelithiasis The presence of stones within the gallbladder is called cholelithiasis. Gallstones can be separated into two large categories: cholesterol stones and pigment stones. Cholelithiasis can be asymptomatic or it can result in biliary colic, which is an episodic right upper quadrant...



Radar 10



The Abdomen, Perineum, Anus, and Rectosigmoid > Chronic cholecystitis with or without Cholelithiasis Book: DeGowin's Diagnostic Examination, 11e ...Chronic cholecystitis with or without cholelithiasis See Cholelithiasis with biliary colic . ...