Chronic biliary colic associated with ketamine abuse

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Introduction: Biliary colic is a common clinical presentation, with the majority of cases being related to gallstone disease. However, rarely, patients may present with biliary symptoms without evidence of gallbladder stones — referred to as acalculous gallstone disease. This case report details a rare case of chronic biliary colic associated with ketamine abuse.

Case presentation: A 24-year-old Caucasian female presented to the emergency department with a history of intermittent right upper quadrant pain associated with nausea and malaise. She had experienced bouts of similar symptoms three times a year for the past 4 years. Various investigations had been conducted during her multiple admissions, which showed possible dilatation of the common bile duct, with no evidence of gallstones.

Conclusion: Patients can present with a dilated common bile duct and an acalculous cholecystitis. This requires considerable investigation, with an emphasis on drug history, especially with the current rise of recreational hallucinogenic drug abuse.

Keywords: gastroenterology, hepatology, substance abuse, ketamine, acalculous gallstones, biliary disease
Here, we present a case of a young Caucasian female who had a 4-year history of ketamine abuse and presented with multiple episodes of right upper quadrant (RUQ) pains and symptoms suggestive of biliary colic. Investigations showed a dilated common bile duct (CBD) with no evidence of gallstone disease.

This study was deemed exempt from full review according to the Southend University Hospital Ethical Committee, UK as this was a retrospective, non-comparative study. Written informed consent was obtained from the patient for publication of this case report and any accompanying images.

**Case report**

A 24-year-old Caucasian female presented to the emergency department with a history of intermittent RUQ pain associated with nausea and malaise. She reported similar episodes of her symptoms three times a year for the past 4 years. The pain was not associated with meals or posture. She did not have any significant past medical history and did not take any regular medicines. On examination, she was hemodynamically stable; there was no fever or tachycardia and her blood pressure was within normal limits. Abdominal examination showed no evidence of peritonitis but revealed tenderness in the RUQ and epigastric regions. Urine dipstick for blood and pregnancy was negative. Full blood count and serum biochemistry showed a normal white cell count of 5.8×10^9/L with normal renal and liver function tests. The initial differential diagnoses by the admitting causality officer included biliary colic and peptic ulcer disease. She was admitted and started on opiate analgesics and antispasmodics and her symptoms gradually improved. Ultrasound scan of the abdomen demonstrated a normal liver and gallbladder with no evidence of gallstones but with a dilated CBD of 8.5 mm. Two days following admission, she underwent magnetic resonance cholangiopancreatography, which again showed no gallstones, but also conversely no evidence of intra- or extrahepatic biliary dilatation with a CBD of normal diameter.

On review of our patient’s previous hospital admissions, we noted that 60 days prior, she had presented with similar episodes of RUQ pain; ultrasound scan of the abdomen and an esophagogastroduodenoscopy were normal. Two years prior to that, she had presented to a different unit with similar symptoms and at the time radiological investigations revealed a dilated CBD of 11 mm with no other abnormality.

On further enquiry into her social history, the patient admitted recreational use of oral ketamine over the past 4 years, all episodes of which coincided with her intermittent abdominal symptoms. She denied the use of any other illicit drugs and only moderately consumes alcohol.

**Discussion**

Ketamine is an N-methyl-D-aspartate receptor antagonist developed in 1962 for use in anesthesia. However, “street ketamine,” which is a close analog of ketamine, has become a commonly used drug for ecstasy. Unlike the other well-known dissociative illicit drugs, ketamine is very short-acting. It takes effect within about 10 minutes, while its hallucinogenic effects last up to 2 hours when ingested orally, making it a popular “club drug” often used by teens and young adults at dance “rave” parties.

Ketamine is metabolized by hepatic microsomal enzymes and has a half-life of 2.5 hours. It is excreted mainly through urine (90%), with the remainder through bile.

Wide variety of symptoms is associated with ketamine abuse. A large number of abusers present with impaired level of consciousness, dizziness, abdominal pain, and lower urinary tract symptoms. The most common physical signs in patients with ketamine abuse are hypertension, tachycardia, and abdominal tenderness.

Severe urinary bladder dysfunction and recurrent episodes of epigastric pain associated with dilated CBD in the absence of gallstones in ketamine abusers has also been reported.

A study by Ng et al investigated the clinical presentations of ketamine abusers in 233 cases. Abdominal pain was the presenting complaint in 21% of cases while abdominal symptoms was this was a list of the common conditions associated with the development of acute acalculous cholecystitis. Adapted from Afshal NH. Acalculous cholecystitis. In: Post TW, editor. UpToDate. Waltham, MA: Wolters Kluwer. Accessed October 18, 2015.

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## Table 1 Risk factors for acute acalculous cholecystitis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Risk Factor</th>
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<tbody>
<tr>
<td>Acute rhegogenous leukemia</td>
<td>End-stage renal disease</td>
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<tr>
<td>Acquired immune deficiency syndrome</td>
<td>Heart failure</td>
</tr>
<tr>
<td>Ampullary stenosis</td>
<td>Hemobilia</td>
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<tr>
<td>Bone marrow transplantation</td>
<td>Immunosuppression</td>
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<tr>
<td>Burns</td>
<td>Infections</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>Major trauma</td>
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<tr>
<td>Childbirth</td>
<td>Mechanical ventilation</td>
</tr>
<tr>
<td>Choledochal cyst</td>
<td>Medications (eg, opiates, sunitinib)</td>
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<tr>
<td>Cholesterol emboli</td>
<td>Metastases to porta hepatitis</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>Multiple transfusions</td>
</tr>
<tr>
<td>Cystic duct obstruction by a percutaneous transhepatic catheter in the bile duct</td>
<td>Nonbiliary surgery</td>
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<tr>
<td>Diabetes mellitus</td>
<td>Sepsis/hypotension</td>
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<td></td>
<td>Total parenteral nutrition</td>
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<td></td>
<td>Vasculitis</td>
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Note: This is a list of the common conditions associated with the development of acute acalculous cholecystitis. Adapted from Afshal NH. Acalculous cholecystitis. In: Post TW, editor. UpToDate. Waltham, MA: Wolters Kluwer. Accessed October 18, 2015.
who had radiological investigations had confirmed dilated bile ducts in the absence of gallstone disease. A case series published by Wong et al10 also presented similar findings.

In our case radiological investigations failed to identify a cause for a dilated CBD. Based on previous studies and case series, we believe that the ketamine abuse is the most likely cause for this. Although the exact pathophysiology of ketamine-induced dilated biliary system is unknown, it is postulated that ketamine increases the flow of resistance across the sphincter of Oddi.11

In conclusion, this case report highlights the importance of drug history taking in patients presenting with abdominal pain and specifically biliary colic.

Acknowledgment
We would like to thank all the NHS staff who tirelessly look after their patients in these difficult times. No funding was provided to write this case report.

Disclosure
The authors report no conflicts of interest in this work.

References