Genuine septation of the gallbladder
A case report
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Summary
Septation of the gallbladder is rarely of any consequence except in differentiating it from a disease of the organ. To date all radiographically demonstrated septa have been considered simple foldings of the wall. A case of genuine septation of the gallbladder after cholecystojejunostomy is presented.

Case report
A 16-year-old boy fell out of a tree and was transfixed by an iron pole which ruptured his duodenum, pancreas, kidney and inferior vena cava. Ultrasonography showed his gallbladder to be normal and to contain no septa. He underwent multiple laparotomies during one of which a cholecystojejunostomy was performed to direct bile away from the injured pancreatic bed. The cholecystojejunostomy was closed 2 weeks later.

Approximately 1 year after the accident the patient was re-examined ultrasonographically for right upper quadrant pain. No cause of the pain was found, but the gallbladder showed two bands of tissue crossing its lumen identical on ultrasonography to septation (Fig. 1). We believe these septa may be fibrinous bands which originated while the cholecystojejunostomy was functional.

Discussion
Simple septation of the gallbladder is relatively common. It is usually without consequence unless it narrows the lumen enough to obstruct a stone forming distal to it. Septation is of two types: (i) the phrygian cap or folding of the fundus which has been reported in 3.5% of gallbladders; and (ii) simple septation seen in 14.5% of gallbladders. The commonest position for septation is at the posterior wall, separating the body from the infundibulum — the so called junctional fold. Histologically the phrygian cap and simple septation can be separated, the former consisting of mucosa, muscle layer and serosa but the latter containing only mucosa and muscle layer.

Until now all radiologically demonstrated septa have been considered to be simple folds varying with position and phase of respiration; the case presented here is of genuine septation showing ultrasonographic features identical with the simple type. Septation is of significance radiologically because it must be recognised as such to avoid confusing it with gallbladder disease. Septation may be difficult to differentiate ultrasonographically from the polypoid variety of cholesterolosis since both show echogenic non-shadowing strips projecting into the lumen. However, septa are thinner and can be seen to fold on the wall rather than to arise from within it as is the case with cholesterolosis. The latter is also more usually multiple and shows flatter heaped up plaques.

In our case the possible cause of the septa may be related to exposure of the gallbladder mucosa to bowel content after cholecystojejunostomy. However, we suggest that trauma or any other interference with the gallbladder wall may result in this phenomenon.

REFERENCES