reported prevalence of 0.7% in US and 10% in India and Japan. Its final diagnosis can be made only after malignancy is ruled out on histopathological examination of resected gall bladder.

Case presentation: 60 years female presented with complaints of pain in right upper abdomen, loss of appetite for 3 months. Physical examination was normal. Abdominal examination revealed tenderness in right upper quadrant and a hard, non tender globular mass suggestive of gall bladder lumpBlood parameters were normal. Contrast enhanced CT scan abdomen reported grossly distended gall bladder with 12 mm calculus at neck, pericholecystic fat stranding, asymmetric wall thickening and few lymph nodes. Serum CA19.9 -103 IU/l.. Diagnostic laparoscopy that ruled out intraperitoneal disease followed by cholecystectomy and wedge resection of liver. Intraoperatively, gall bladder was found to be hard, elongated, densely adhered to GB fossa with multiple calculi in it. Histopathologically greyish-yellow streaks in the gallbladder wall, transmural inflammation with dense lymphoplasmacytic infiltration and fibrosis, perineural plasma infiltrate, one of the areas showing storiform fibrosis, suggesting xanthogranulomatous or IgG4 cholecystitis. No malignancy present. Serum IgG levels were raised but IgG4 levels were normal. Immunohistochemistry for IgG4 plasma cells in the specimen was negative.

Conclusion: Xanthogranulomatous cholecystitis is a perfect mimicker of carcinoma gall bladder and diagnosis is difficult, both pre and intraoperatively. It is a differential for IgG4 cholecystitis also which though rare isolated entity, is usually a part of spectrum of IgG4 related sclerosing diseases.

EP03C-013
ASYMPTOMATIC CHOLECYSTOCOLIC FISTULA TREATED BY LAPAROSCOPIC SURGERY WITH ACCURATE DIAGNOSIS BEFORE SURGERY

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Cholecystocolic fistula (CCF) is a rare and late complication of gallbladder disease. The cause of CCF is known to be due to peptic ulcer, gallbladder disease, malignant tumor, trauma, and postoperative complications. The proper method of treatment is to perform cholecystectomy and to identify and alleviate the CCF. However, This surgery is not always possible due to technical difficulties and disease severity. CCF is difficult to diagnose preoperatively and CCF operation without an accurate preoperative diagnosis can lead to more complicated surgery and can lead to surgeons in more difficult situations or to endanger patients. We would like to report the asymptomatic CCF successfully treated by laparoscopic surgery with accurate diagnosis before surgery.

EP03C-014
MIRIZZI SYNDROME: SURGICAL TREATMENT OPTIONS

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Introduction: Mirizzi syndrome occurs approximately on 0.5 to 4% of the patients with cholelithiasis.

Methods: 34 patients underwent surgical treatment.

Results: Mirizzi I diagnosed in 6 patients - cholecystectomy performed. Mirizzi II (9 patients) - cholecystectomy with plastics of fistula, in 6 - external drainage of CBD, 1 - choledochoduodenostomy performed. Mirizzi III (4 patients) - in 2 patients cholecystectomy with plastics of CBD. In 2 cases hepaticojejunostomy in our modification performed. Mirizzi IV (5 patients) subtotal cholecystectomy, in 4 with reparation of CBD. In 1 patient - hepaticojejunostomy in our modification. Mirizzi Va (8 patients), 4 (50 %) patients came with signs of acute cholecystitis with formation of subhepatic or subdiaphragmatic abscesses. In all cases, cholecystoduodenal fistula was detected. All 4 patients underwent subtotal cholecystectomy with reparation of CBD using gallbladder tissue and plastics fistula. 4 (50%) patients delivered with symptoms of obstructive jaundice. In 1 case cholecystocolic, in 3 - cholecystoduodenal fistula diagnosed. Subtotal cholecystectomy with CBD plastics and plastics of enteric fistulas performed. Mirizzi Vb (2 patients): delivered in severe condition with of endotoxic shock and symptoms acute small bowel obstruction. During intervention large concrements (4 and 5 cm) were found causing small bowel obstruction. Enterotomy with removal of concrements performed.

Conclusions: Surgical treatment of patients with Mirizzi syndrome requires individualized tactics.

EP03C-015
EARLY LAPAROSCOPIC CHOLECYSTECTOMY IN ACUTE MILD BILIAR PANCREATITIS

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Introduction: The International Association for the Study of Pancreatic Disease recommends cholecystectomy as early as possible, once the acute mild biliar pancreatitis episode is solved; however, the American and British Society of Gastroenterology recommends it between 2 and 4 weeks. The objective of this work is analyze the results of cholecystectomy performed early in patients with mild acute biliary pancreatitis.

Method: Retrospective observational study between January 2015 and December 2017. The variables under study were hospitalization days, age, sex, morbility, mortality, pain at the time of surgery, pre-operative amylasemia, intraoperative cholangiography, conversion rate, persistence of SIRS in the pre-operative period, recurrence of the disease, and indication or not of CT scan.

Results: A total of 77 patients were admitted with a diagnosis of acute pancreatitis, of those, 41 were diagnosed with a diagnosis of PAB. 6 patients underwent surgery before 48 hours and 35 after 48 hours. Those operated before 48 hours were admitted to the operating room with amylasemia lower than 300 UI/l. Of the 35 patients who underwent surgery after 48 hours, the average amylasemia was 96 UI/l. 17 patients (41,4%) underwent CT scan. All of the patients underwent CIO and only 2 presented choledocholithiasis