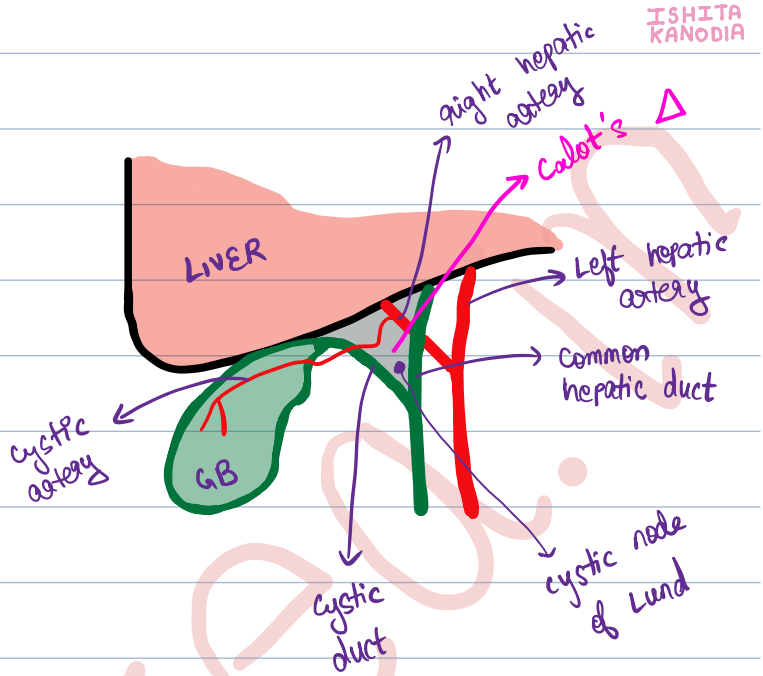
Cystohepatic Triangle of Calot



Boundaries:

Right side: cystic duct

Left side: common hepatic duct

Above: inferior surface of liver

Apex: faces downwards towards cystic & common hepatic ducts

Contents: – right hepatic artery
– cystic artery
– cystic lymph node of Lund

→ in this Δ, most of the aberrant segmental right hepatic ducts & arteries are encountered

→ this Δ helps the surgeon to locate pedicle of gall bladder & its ligation in cholecystectomy

Cystic node of Lund ⇒ solitary node

↳ present in apical part of Δ

→ receives most of the lymph from GB

→ constantly enlarged in cholecystitis

Applied Aspect:

Cholecystitis: inflammation of GB

↳ acute or chronic

Acute cholecystitis: occurs usually in adult women

↳ characterised by: – sudden pain in hypochondrium referred to right scapula or tip of right shoulder
– vomiting
– positive murphy's sign ⇒ if finger is pressed under right costal margin at tip of 9th costal cartilage when patient is asked to take deep breath, she/he feels sharp pain & winces

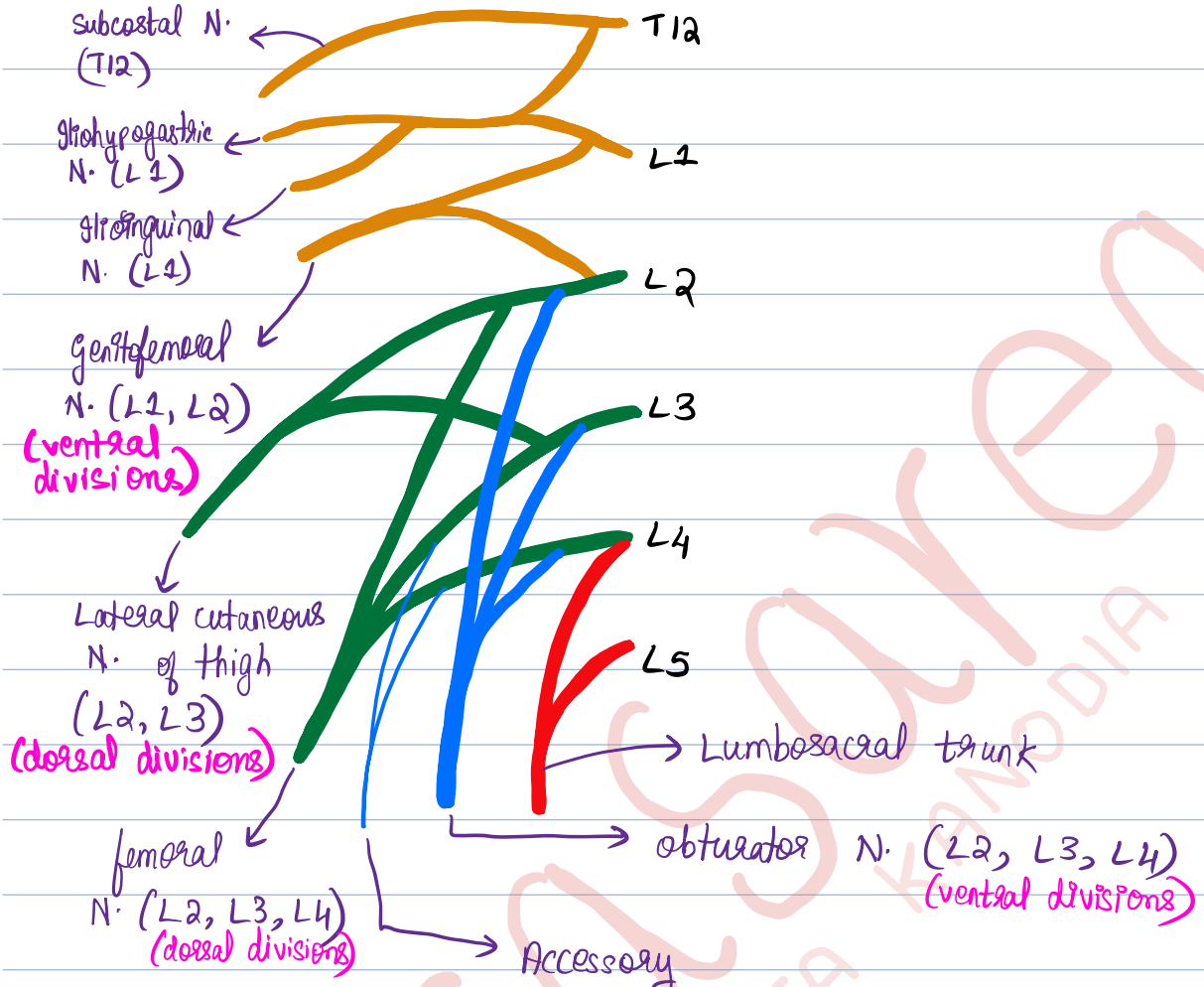
→ symptoms of cholecystitis are aggravated on taking fatty meals as GB contracts to pour bile into duodenum when fat reaches
(fat in duodenum induces CCK-PZ which reaches GB & stimulates its contraction)

Chronic cholecystitis: usually leads to formation of stones in GB (cholelithiasis)
↳ occurs typically in – fat
– fertile
– flatulous female of forty.

Referred Pain of GB: inflammation of GB may cause irritation of subdiaphragmatic parietal peritoneum which is supplied partly by phrenic nerve (C3, C4, C5)
→ this leads to referred pain over tip of right shoulder (supplied by supraclavicular nerves [C3, C4]).

Courvoisier's Law: states that obstructive jaundice with distended & palpable GB is most likely due to extrinsic obstruction of CBD
→ on the contrary, obstructive jaundice with non-distended, non-palpable GB is due to intrinsic obstruction of CBD.

Lumbar Plexus:



Sacral Plexus: