Mesothelial cyst at porta hepatis

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Mesothelial cysts are fluid-filled sacs lined by mesothelial cells. They are rare lesions that have been known to occur at various sites, but have not been reported at the porta hepatitis. We report a 45-year-old woman with mesothelial cyst at the porta hepatitis that was detected incidentally during open cholecystectomy. [Indian J Gastroenterol 2001;20:35-36]

Key words: Benign cyst

A variety of benign lesions have been documented to compress or obstruct the extrahepatic biliary tree. Mesothelial cysts have been known to occur at various intra-abdominal sites but have not so far been reported at the porta hepatitis.

A 45-year-old woman was admitted with complaints of pain in the right upper quadrant of the abdomen for three years. Abdominal examination was unremarkable. Liver profile revealed normal serum bilirubin, AST and ALT levels. Alkaline phosphatase level was markedly raised (845 U/L, normal up to 305 in adults). Ultrasonography detected multiple gall bladder calculi and normal wall thickness. The common bile duct and intrahepatic biliary radicles were not dilated.

In view of the raised alkaline phosphatase level, we planned open cholecystectomy and peroperative cholangiogram. At exploration, the gall bladder contained multiple calculi. There was a densely cystic, white swelling, measuring 3 cm x 3 cm x 2 cm, at the porta hepatitis. The swelling was displacing the hepatic artery to the right and causing extrinsic compression of the confluence of the hepatic ducts.

Peroperative cholangiogram through the cystic duct failed to clearly delineate the left hepatic duct and the confluence. No filling defects suggestive of calculi were seen in the biliary tree. The cyst was aspirated and yielded turbid white fluid. It was then carefully dissected out and excised. No feeder ves-

Fig: Microphotograph of wall of mesothelial cyst (hematoxylin & eosin, 250X)

The postoperative period was uneventful and the patient was discharged on the seventh day. Serum alkaline phosphatase level at discharge was within normal limits (275 U/L).

Sections from the cyst showed a fibrocollagenous cyst wall lined by 2-3 layers of cuboidal cells, typical of mesothelial cyst (Fig). The absence of smooth muscle in the cyst wall ruled out a lymphatic cyst. The gall bladder showed features of chronic cholecystitis.

Numerous benign lesions have been described to cause extrinsic compression to the biliary tree at the confluence of the hepatic ducts. Cystic lesions such as hydatid cysts, lymphatic cysts and non-parasitic cysts of the liver have also been shown to cause similar extrinsic compression. We found no report of a mesothelial cyst at the porta hepatitis. Mesothelial cysts have been reported from various abdominal sites, including the adrenal gland, mesentry, diaphragm, peritoneal surfaces, round ligament and the gall bladder.

Pathologically, these cysts have a lining of mesothelial cells. Immunohistochemistry has been described to confirm the origin of the mesothelial lining. Definitive pre-operative diagnosis is difficult as the lesion is not usually suspected and most of these cysts have been discovered at laparotomy or incidentally. The cysts can be treated by excision. Resection of the affected organ may be necessary. Sclerosant therapy has been described as an adjunct for recurrent, multilocular mesothelial cysts of the peritoneum.

References


Implantation malignancy after laparoscopic cholecystectomy

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Laparoscopic cholecystectomy may result in spillage of gall bladder contents during dissection or delivery of gall bladder through the umbilical port. We report a 50-year-old man who underwent laparoscopic cholecystectomy for suspected calculous cholecystitis. Histology showed a single focus of adenocarcinoma in the gall bladder. There was spillage of gall bladder contents at the umbilical port during delivery. Six months later, he developed adenocarcinoma at the port site. This was treated by wide excision. [Indian J Gastroenterol 2001;20:36]

Key words: Gall bladder carcinoma

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t all bladder perforation and spillage of bile and gallstones into the peritoneal cavity has been reported in up to 40% of cases undergoing laparoscopic cholecystectomy. This may be responsible for complications like abscess and implantation of malignant cells at the port site. We report a patient who developed adenocarcinoma at the port site resulting from spilled malignant gall bladder contents.

A 50-year-old man presented with clinical features suggestive of biliary lithiasis; ultrasonography confirmed the presence of gallstones. He underwent laparoscopic cholecystectomy uneventfully, but the gall bladder ruptured during delivery through the umbilical port. Histological examination of the gall bladder revealed a single focus of adenocarcinoma in the mucosa.

After about six months, he presented with a small protuberant growth at the port site, suggesting chronic sinus with granulation tissue. Exploration of the sinus was done and the patient responded favorably. Two months later, recurrence was seen at the port site (Fig). Fine needle Aspiration cytology of this lesion showed adenocarcinoma. Other metastatic work-up

References


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