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Intraductal papillary mucinous neoplasm of the biliary tract: a lesion of the bile duct lumen.

Eugenia Sánchez Rodríguez¹, Alejandra Caminoa², José Ramón Foruny Olcina¹ and Enrique Vázquez Sequeiros¹

Departments of ¹Gastroenterology and Hepatology and ²Pathology. Hospital Universitario Ramón y Cajal. Madrid, Spain

Correspondence: Eugenia Sánchez Rodríguez. Department of Gastroenterology and Hepatology. Hospital Universitario Ramón y Cajal. M-607, km. 9, 100, 28034 Madrid, Spain

e-mail: eugenia.sanchez.rodriguez@gmail.com

CASE REPORT

The case was an 87-year-old female with constitutional syndrome and elevation of cholestatic enzymes detected repeatedly over a period of two years. Serum analysis showed blood alkaline phosphatase at 232U/L (42-141) and Gamma-glutamyltransferase at 225U/L (7-30). A magnetic resonance imaging showed mild ectasia of the intrahepatic left bile duct (BD) and a short-segment stricture of the proximal common hepatic duct (CHD) (Fig. 1). Endoscopic ultrasound confirmed the dilatation of the BD and revealed a proximal CHD enlargement and the presence of a 13 mm anechogenic polypoid mass in the gallbladder and two intraductal masses of the same characteristics in the CHD (7 and 20 mm in diameter, respectively) (Fig. 2). Cytological examination of the endoscopic ultrasound-guided fine needle aspiration of the latter lesion was performed. The tumor consisted of prominent papillary proliferation of an atypical columnar epithelium with over-secretion of mucin and high-grade dysplasia (Fig. 3). The patient was referred for surgery, which she refused.

DISCUSSION

Intraductal papillary neoplasm of the bile duct (IPNB) is a rare entity characterized by papillary growth within the bile duct lumen (1) and is currently regarded as a biliary counterpart of intraductal papillary mucinous neoplasm of the pancreas (1). It can develop anywhere along the biliary tree (1) and up to 40% of lesions have mucin overproduction (1,2) and multiple lesions occur occasionally. The most common clinical findings are abdominal pain, jaundice or cholangitis. Some patients have no symptoms and the tumor is identified incidentally during imaging for other purposes (1). The diagnosis requires a careful assessment of imaging findings and cyto-histological evaluation (2). IPNB is a premalignant lesion which can evolve into invasive cholangiocarcinoma, although patients with IPNB have a better prognosis than those with conventional cholangiocarcinoma (2,3). A radical treatment strategy should be planned accordingly (3).

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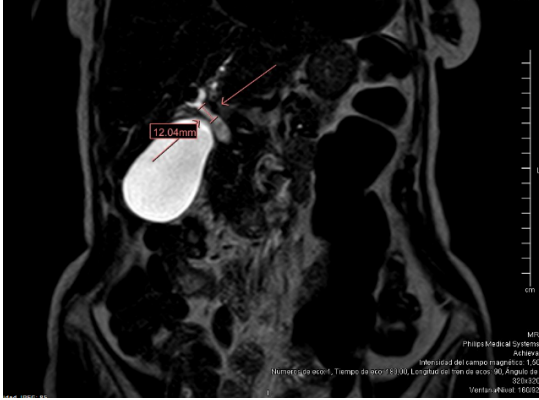


Fig. 1. Magnetic resonance imaging showing a short-segment stricture of the proximal CHD.

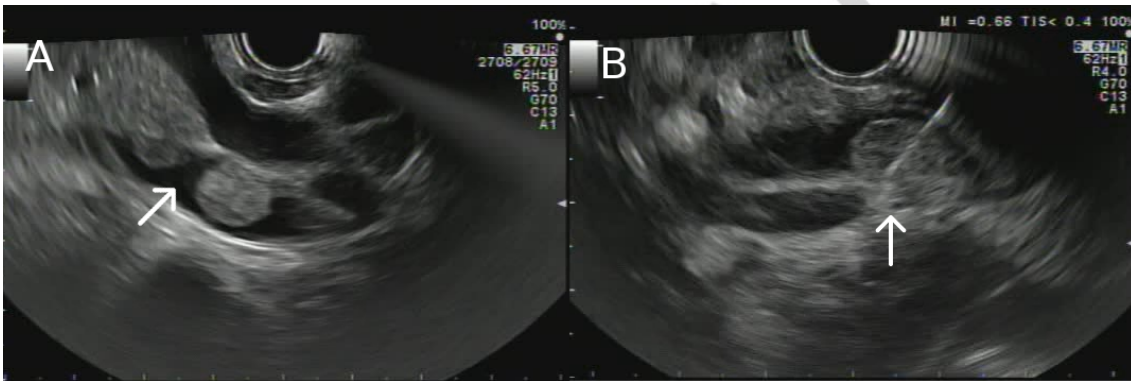


Fig. 2. Endoscopic ultrasound showing two polypoid intraductal masses (7 and 20 mm in diameter, respectively) located in a dilated common bile duct (A). Endoscopic ultrasound-guided fine needle aspiration of the largest lesion was performed (B).

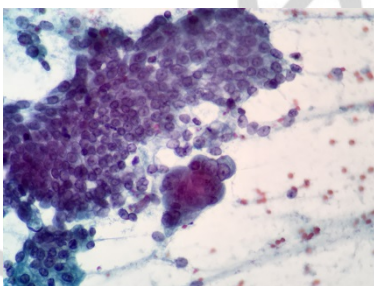


Fig. 3. Prominent papillary proliferation of an atypical columnar epithelium with over-secretion of mucin and high-grade dysplasia. Hematoxylin-eosin. 60x.