Title: 
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It seems like cholangiocarcinoma but it is not: discovering the choledochal cyst

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Dear Editor,

A 52-year-old female was referred for a study of a left intrahepatic bile duct dilation with an initial suspicion of Klatskin. Analytically, there was no cholestasis and tumor markers were negative. On echoendoscopy, there was dilation of the intrahepatic bile duct to the confluence at the level of the left hepatic lobe, with no evidence of a lesion that could be biopsied by fine needle aspiration (FNA). An endoscopic retrograde cholangiopancreatography (ERCP) was performed and the common bile duct and right liver were slightly dilated, with no alterations by cholangiography. A 1-cm stenosis and large suprastenotic dilation were observed in the left hepatic duct, close to the hilum. Cytology was negative for malignancy and the stenosis was dilated. Abdominal magnetic resonance imaging (MRI) was repeated three months later with a dropscical vesicle, and a slight dilatation of the right intrahepatic bile duct and dilation of the left hepatic bile duct were observed with an image suggestive of stenosis. The extrahepatic bile duct was dilated (12 mm) and gradually tapered to the papilla. A Todani’s type IVa choledochal cyst was identified (Fig. 1). Resection of the cyst and Roux-en-Y hepatic jejunostomy were decided by an expert committee.

Discussion
Choledochal cysts are a rare congenital anomaly, consisting of single or multiple dilation of the intra and/or extrahepatic bile ducts. Incidence is higher in the Asian population (1:1,000) than in the Western population (1:150,000). It is more frequent in females (3.5:1) and 60-80 % are detected during childhood (1). The symptoms vary, from asymptomatic patients to those who may develop stones and biliary stenosis, cholangitis, pancreatitis, secondary biliary cirrhosis and spontaneous rupture of the cyst. The risk of cholangiocarcinoma is 2.5-25 % in adults (2) and 0.7 % in children (3). Diagnosis is sometimes challenging and it is difficult to differentiate from cholangiocarcinoma, as in this case. When there is dilation of the biliary tree, the best diagnostic methods are echoendoscopy and MRI. The presentation of symptoms and the elevation of cholestasis enzymes increase its diagnostic profitability. In recent years, the use of endoscopic cholangioscopy in the study of common bile duct cysts has also been described (4).
Choledochal cysts follow the Todani classification and their treatment consists of a cyst resection and Roux-en-Y hepaticoduodenostomy or hepaticojejunostomy (5). The risk of malignancy is present after resection (6 %). Thus, periodic monitoring of the patient is necessary (2).

References
Fig. 1. A. Coronal section of an abdominal MRI. A dilated left hepatic bile duct, a 12 mm extrahepatic bile duct that progressively tapers to the papilla and a Todani’s type IVa common bile duct cyst (arrow) are seen. B. Axial section of an abdominal MRI. A Todani’s IVa cyst is seen with cystic dilation of the common bile duct that compromises the intra and extrahepatic bile duct (arrow).