Non-parasitic hepatic cysts causing obstructive jaundice: two cases

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Non-parasitic hepatic cysts rarely cause jaundice. We report two patients with such lesions treated by percutaneous drainage. [Indian J Gastroenterol 2003;22:26]

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Non-parasitic hepatic cysts are rarely symptomatic; symptoms are due to pressure effects on adjacent organs, including the bile ducts causing obstructive jaundice. These cysts do not communicate with intra- or extrahepatic bile ducts.

Case 1: A 42-year-old man came with progressive obstructive jaundice and epigastric lump of 6 months' duration. He had intermittent high grade fever for one month. Clinically the patient had hepatomegaly with cystic consistency. Ultrasonography done earlier reportedly showed presence of two large abscess cavities in the liver, one in the left lobe of 15 cm x 11 cm and the other in the left lobe of 7.2 cm x 5.4 cm. The patient was treated with metronidazole, chloroquine and emetine over six moths. Repeat ultrasonography showed two large cystic cavities in the right and left lobes of the liver adjacent to each other. Serum bilirubin was 9.4 mg/dL (direct 7.8). Serum alkaline phosphatase was 840 IU/mL (normal 80-300). Leukocyte count was normal. We aspirated 250 mL thick green fluid, which on culture did not grow any organism. Indirect hemagglutination tests for Entamoeba histolytica and Echinococcus granulosus were negative. After 4 days ultrasonography showed the cyst to have increased to the previous size. There was no change in serum bilirubin level.

A T1P infant feeding tube was inserted percutaneously into the cyst through the epigastric region. The tube drained about 800 mL of bilious fluid every day. Dye study done through the tube showed the cyst to be situated at the hilum above the confluence of the right and left hepatic ducts. The cystic cavity was communicating with the biliary radicals (Fig). After 10 days serum bilirubin levels reached normal value. Drainage stopped after 3 months, with complete disappearance of the cystic cavity, when the drainage tube was removed. Over the past two years the patient is asymptomatic and ultrasonography has shown no recurrence of the cyst.

Case 2: A 29-year-old man presented with obstructive jaundice and epigastric lump since one month. Clinical examination showed non-tender hepatomegaly. Ultrasonography revealed an abscess cavity measuring 15 cm x 11 cm, occupying the junction of the right and left lobes of the liver. Serum bilirubin was 9.9 mg/dL (direct 6.3). Serum alkaline phosphatase was 1024 IU/mL. Aspiration of the cavity revealed green fluid. Culture of the fluid did not grow any bacteria. Indirect hemagglutination test was negative for Entamoeba histolytica and Echinococcus granulosus.

A T1P infant feeding tube was inserted percutaneously into the cyst cavity; it drained about 700 to 800 mL bile daily. Serum bilirubin came to normal value one week after establishing drainage. Dye study done through the tube showed a large cavity at the hilum of the liver but communication with the biliary radicals was not evident. ERCP demonstrated communication of the right and left hepatic ducts with the cyst. It took 4 months for the drainage to cease, when the tube was removed. The patient has been followed up for 18 months and there has been no recurrence of the cyst or jaundice.

Non-parasitic hepatic cysts causing obstructive jaundice are uncommon. Kanai et al reviewed 13 cases from literature and added one of their own case. Both our cases had a single large cyst each as shown by contrast studies, though ultrasonography showed an appearance of two adjacent cavities.

In an earlier report, after drainage and instillation of minocycline hydrochloride as a sclerosant, it took nine months for the disappearance of a large cyst and dilated intrahepatic bile ducts. In both our cases since the cysts were shown to be communicating with the intrahepatic ducts we avoided using sclerosants. Percutaneous drainage alone was successful in treating the cysts as well as relieving the obstructive jaundice.

References


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Fig: Case 1: Dye study through percutaneous drainage tube shows cyst cavity and right and left biliary systems.

26 Indian Journal of Gastroenterology 2003 Vol 22 January - February