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Giant choledochal cyst

Introduction

The incidence of choledochal cyst is 1 in 100,000 to 150,000 live births with a 3:1 to 4:1 female preponderance. It is reportedly more common in Asian populations(particularly Japanese).[1] More than 60% present during the first year of life andabout 20% presents in adulthood.[2] The etiology of choledochal cyst is still controversial. The "common channel theory" proposed by Babbitt et alis the most commonly accepted theory.[3] We report the case of a choledochal cyst type 1 in a 14-year-old girl in which there was huge dilatation of the common bile duct occupying almost right half of the abdomen and containing about 2400 cc of bile.

Case Report

A 14-year-old girl was admitted with a 3-day history of pain abdomen, jaundice and fever. She noticed fullness in the right side of herabdomen since 1 year which was asymptomatic but progressive in nature. She also had past history of fever and jaundice one and half month agofor which she was hospitalized.On general examination, she had tachycardia with mild pyrexia.Per abdomen examination revealed tenderness in the right hypochondrium and a well defined cystic lump in the whole right hemiabdomen extending from right hypochondrium to right iliac fossa. Blood investigations revealed hemoglobin 8.9g/dL and total leukocyte count of 14600/cumm with 76% polymorphs and 20%lymphocytes. Serum bilirubin was 4.2 mgwith a direct component of 2.5mg/dL. Alkaline phosphates was elevated (789U/L) and ALT was 153U/L. Serum amylase was normal. Ultrasonography revealed cystic lesion arising from porta suggesting choledochal cyst type1.Magnetic resonant cholangiopancreatogram confirmed this diagnosis (**Figure 1-A & 1-B**). She was managed with IV antibiotics, adequate hydration and symptomatic care. She responded well and became painfree andafebrile. Surgery was planned. On exploration, there was a giant choledochal cyst of approximately 15 cm ×18 cm ×9 cm sizes, occupying almost the entire right half of the abdomen (**Figure 2**).The duodenum and right colon were pushed to left. Aspiration yielded 2400cc of bile. The entire cyst was dissected out from the hilum superiorly tothe junction with pancreatic ductinferiorly. Portal vein and hepatic artery were safeguarded. There were dense pericholecystic adhesions due to previous attacks of cholangitis. The cyst along with the gall bladder was excised. Roux en Y hepaticojejunostomy was performed to reestablish the biliary enteric communication. Oral feeding was initiatedsecond day postoperative. ALP touched baseline after the seventh

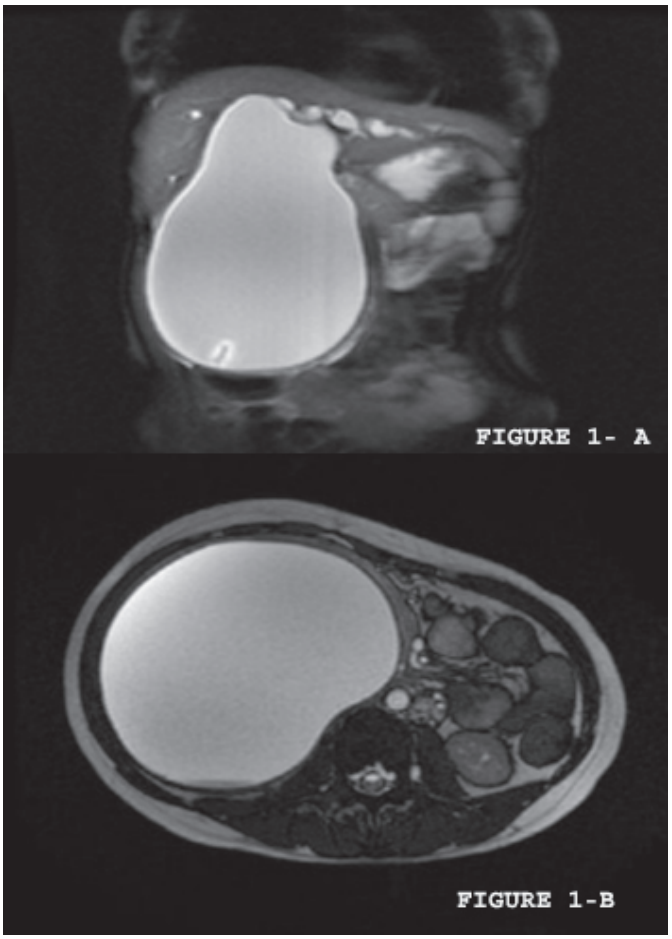

Figure 1: (A&B) MRCP showing coronal and cross sectional view of giant choledochal cyst respectively

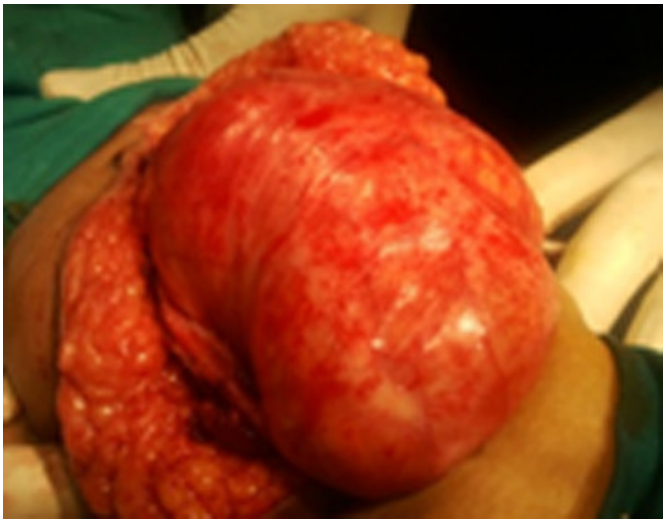

Figure 2: Intra operative photograph of giant choledochal cyst.

postoperative day.There was no evidence of malignancy on histopathological examination. The patient is presently doingwell at 1-year follow up.

Discussion

Choledochal cysts are rare congenital cystic dilatations of the biliary tract that can involve the intra- or extrahepatic bile ducts. The size of choledochal cyst varies, and the maximum diameter of cyst can reach upto20 cm.[4]

The classical triad of abdominal pain, jaundice and a right hypochondrial mass (as was in our case) is seen in less than 20% of patients. The main diagnostic tool for detection of a choledochal cyst, especially in childhood, is ultrasonography. Magnetic resonance cholangiopancreatography (MRCP) is the best method for noninvasive imaging of bile duct cysts. Surgery is the treatment of choice for a choledochal cyst. Complete excision of all cystic tissue is recommended because of the risk of recurrent cholangitis and the high risk of malignant degeneration. The risk of malignancy ranges from 3.2% to 39.4%.The risk of cancer in patients who had choledochal cyst diagnosed in the first decade is 0.7%, 11 to 20 years is 6.8% and more than 20years is 14.3%.[5] Robot-assisted resection of choledochal cysts and hepaticojejunostomyis therecently introduced modality in cyst management.

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Duodenal Leishmaniasis Mimicking Celiac Disease

Introduction

Visceral leismaniasis is considered as opportunistic infection in immunosuppressed patients particularly HIV infected. However, in the endemic areas like India, South America, Northeast Africa, and the Mediterranean basin it is quite common in immunocompetent persons as well. The atypical presentation of leishmaniasis is usually in association with HIV coinfection. [1-3] We present a case of atypical presentation of leishmania infection in a non immunocompromised patient who came with clinical symptoms mimicking celiac disease.

Case report

A 32 year old female presented in gastroenterology OPD with complaints of chronic diarrhea and weight loss for one year and fever for one month. Blood tests revealed normocytic normochromic anemia and leucocytosis. Anti transglutaminase