Radical Excision of
Huge Biliary Mucinous Cystic Neoplasm of the Liver: A Case Report

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Introduction

Biliary cystic tumor (BCT) is a rare variant tumor of bile duct and a small subset (3% – 5%) of hepatic cysts. The pathognomonic pathologic features of BCT is described as a multilocular lesion lined by columnar epithelium with an accompanying dense cellular “ovarian-like” stroma. Although rare, the management of BCT is important because it may have a risk of malignant transformation as high as 20% to 30%. Therefore, the accurate diagnosis and management of BCT is critical.

Case

A 40-year-old woman who had developed epigastric distension and pain with 4 weeks had revealed 20*15 cm sized huge cystic neoplasm with focal intraluminal polypoid and multiple septated lesion located in central liver by imaging studies (Fig 1). At admission, laboratory findings had shown elevated AST and ALT due to compression effect by tumor. She underwent left hemihepatectomy with cholecystectomy (Fig 2) and discharged at postoperative 10th day without problem. Histology revealed mucinous cystic neoplasm with low grade intraepithelial neoplasia which was 20.0*15.0*12.0 cm and 2900 gm (Fig 3). She has followed up without problem or recurrence 14 months after operation.

Discussion

Biliary cystic tumors (BCTs) most commonly presented as large cysts in women and are slow-growing tumors with symptoms generally appearing as the cyst enlarges and occasionally discovered incidentally on imaging studies. It appears as a cystic, fluid-filled, well-circumscribed tumor with multiple septa and/or internal papillary lesion. The presence of solid nodular masses, calcification in the pseudocapsule and septa and thickening of the cyst walls are indicative of malignancy. Although these lesions may represent premalignant or malignancy, research for appropriate management, outcomes and prognosis of BCT are limited. Some data showed that the risk factor of recurrence included operative intervention (ie, unroofing/fenestration vs formal hepatic resection) and pathological findings (ie, presence vs absence of spindle cell/ovarian stroma). Moreover, while male sex was associated with the risk of biliary cystadenocarcinoma (BCAC), there is no specific radiographic marker which could reliably differentiate biliary cystadenoma (BCA) from BCAC.

Conclusion

Radical excision of BCT can be the treatment of choice and make better for outcomes because recurrent rates are high after partial excision or aspiration. Therefore, surgeons should do complete excision of the lesion and all patients of BCTs is required long-term surveillance because of the risk of recurrence.