Case presentation

Oylum Ekiztaş
Canan Aycan
Özgür Atmaca

Saas-Fee Switzerland
January 2012

History

- A 61 year-old male patient presented to emergency department with stomach ache located on epigastrium, jaundice and dark urine.
- The symptoms had started ten days ago with stomach ache and after a week, jaundice had been noticed.
- The patient had symptoms like fatigue, weakness and jaundice. Neither weight loss nor anorexia were present.

Medical history and physical examination

- The patient had COPD.
- He had been using ipratropium bromide and albuterol sulfate irregularly.

- Temp: 36.6 C,
- BP: 120/80,
- HR: 92/minute
- Jaundice+
- Epigastric and right upper abdomina tenderness
- All other findings were normal.

- **This is a patient with jaundice and stomach ache.**

- Hemogram: Normal
- Biochemical tests: Normal (except liver function tests)
- SGOT 180 iu/ml (13-41 MU/ml)
- SGPT 262 iu/ml (10-40 U/L)
- T. BIL 9.6 mg/dl (0.2-1.2 mg/dl)
- D. BIL 5.5 mg/dl (01.1-0.5 m/dl)
- ALP 503 iu/ml (32-92 MU/ml)
- GGT 447 U/L l (7-64 U/L)

- INR: Normal
- Urine test: Urobilinogen+ bilirubine +
- Viral hepatite markers: Negative

Because of the sudden onset of the symptoms, our hypothesis for the diagnosis was an obstuctive jaundice so we performed hepatobiliary USG:

- Gall bladder was normal.
- Intra/extra hepatic bile ducts were normal
- There were a few hypoechoic lesions one of which is 39x39 mm size, at the left hepatic lobe.
- ALSO…
- CA19-9 >2084 (0-35 IU/ml). Other tumour markers were normal.
- Faecal occult blood test : Positive. (4+)

Any diagnosis?

What should we do next?

The lesions seen in liver, the high levels of CA 19-9 and the positive faecal occult blood test, led us think about a metastatic malignancy of gastrointestinal tract.

- **Total Colonoscopy:** Three polyps with the size of 2-4 cm were seen at the rectosigmoid section and removed with polypectomy.
- (Pathology: Benign adenomatous polyp)

- **Upper GI Endoscopy**: There were 2 colons of 2. degree esophageal varices.

- In the first USG there was no signs of cirrhosis and portal hypertension. But we found varices.

The USG was performed again:

- The left liver lobe parenchyme was heterogeneous. Intra and extra hepatic bile ducts were dilated. And a gall stone was seen in the choledochus. Gall bladder was full of gall mud but there was no gall stone in it.

- **An extrahepatic cholestasis caused by choledocholithiasis.**
- **What should we do next?**

ERCP was performed:

- A number of three black gall stones were extracted (One of them was 1.5 cm), and endoscopic sphincterotomy was done.
- After ERCP the stomach ache regressed, transaminase levels became normal and cholestasis enzymes decreased but bilirubine levels increased

Laboratory

	Initial	After ERCP	Later
• SGOT (13-41 MU/ml)	180 iu/ml	70 MU/ml	39 MU/ml
• SGPT (10-40 U/L)	262 iu/ml	133 U/L	36 U/L
• T. BIL (0.2-1.2 mg/dl)	9.6 mg/dl	11.3 mg/dl	15.4 mg/dl
• D. BIL (01.1-0.5 m/dl)	5.5 mg/dl	7.1 mg/dl	9.4 mg/dl
• ALP (32-92 MU/ml)	503 iu/ml	425 MU/ml	201 MU/ml
• GGT (7-64 U/L)	447 U/L l	374 U/L	202 U/L

- Despite the stone extraction and sphincterotomy by ERCP, the patient still had jaundice.

- Cholangitis?
- Pancreatitis?
- Any remaining stones?
- Another obstruction?
- What to do now?

USG:

Intrahepatic bile ducts were still dilated.

But no lesions were seen.

ERCP:

- No more gall stones were detected but during the cholangiography it is seen that there was no contrast transition to the left intrahepatic bile ducts and little contrast transition to the right intrahepatic bile ducts.

MRCP:

- MRCP showed us a mass with the size of 7.5x11 cm , located at the bifurcation of the common bile duct, spreading to both right and left intrahepatic bile ducts.

- A biopsy specimen was taken and the pathology result came as :

Cholangiocarcinoma

Klatskin tumour type 4, according to the Bismuth-Corlette classification

CHOLANGIOCARCINOMA

- This a rare malignancy of gastrointestinal tract. The most known reason is primary sclerosing cholangitis.
- There are three types of cholangiocarcinoma:
  - Hilar (Klatskin), distal and intrahepatic type.
- Patients usually present with jaundice, stomach ache, anorexia and weight loss.

- The only curative treatment is surgery but most of the lesions are at late stage and inoperable when detected.
- Chemotherapy and radiotherapy can be performed, but not much succesful.
- Palliative surgery or gall drainage by ERCP /PTC is the only thing we can do at the late stage .

Thank you very much for your participation and attention