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SCIENTIFIC LETTERS

Pancreatitis and cholangitis following intraductal migration of a metal clip 5 years after laparoscopic cholecystectomy

Pancreatitis y colangitis secundaria a la migración intraductal de un clip de metal 5 años después de una colecistectomía laparoscópica

A 58-year-old male was admitted at our hospital for severe epigastric pain, nausea and vomiting. On physical examination patient was sweaty, restless and with marked tenderness in the epigastrum. Five years earlier he had gone through an uneventful laparoscopic cholecystectomy (LC) for cholelithiasis. Initial laboratory blood test were as follows: WBC: 11.6×10^9/L; ALT: 1124 IU/L; AST: 1042 IU/L; ALP: 149 IU/L; TB: 3.6 mg/dL; Amylase: 3793 U/L; and CRP: 3 mg/L. The initial imaging exams did not show abnormalities (chest and abdominal X-ray; abdominal ultrasound). There was a clinical deterioration in the first 48 h with the development of fever, hemodynamic instability, increasing inflamatory parameters (WBC: 15.6×10^9/L; CRP: 96 mg/L) and augmented TB (7.5 mg/dL). Given the suspicion of a concomitant acute cholangitis, patient started antibiotics and an abdomen computed tomography (CT) scan (Fig. 1) was performed, revealing discreet extrahepatic ductal dilatation secondary to ocluding hyperdense material in the lower common bile duct and features compatible with acute pancreatitis. The radiological characteristics of the foreign body were consistent with a metal endoclip used in the previous LC. The patient underwent and emergent endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy and immediate removal of the migrated clip (Fig. 2). The posterior bile duct exploration was negative for lithiasis. This resulted in a hasty clinical and laboratorial improvement. Metal endoclips migrations after LC are a rare and unpredictable event with an unclear

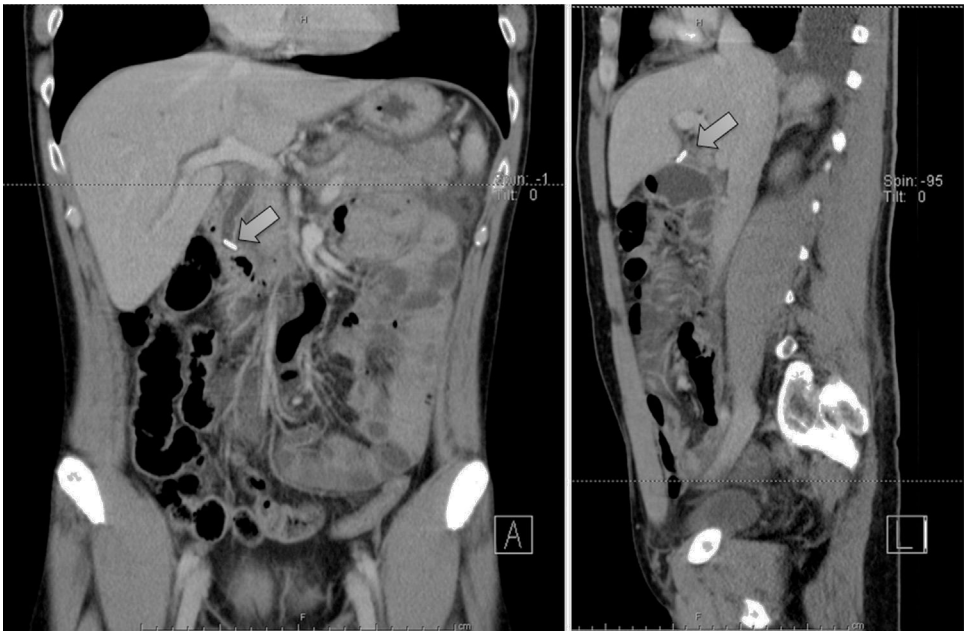

Figure 1 CT scan demonstrating a surgical clip in the common bile duct.

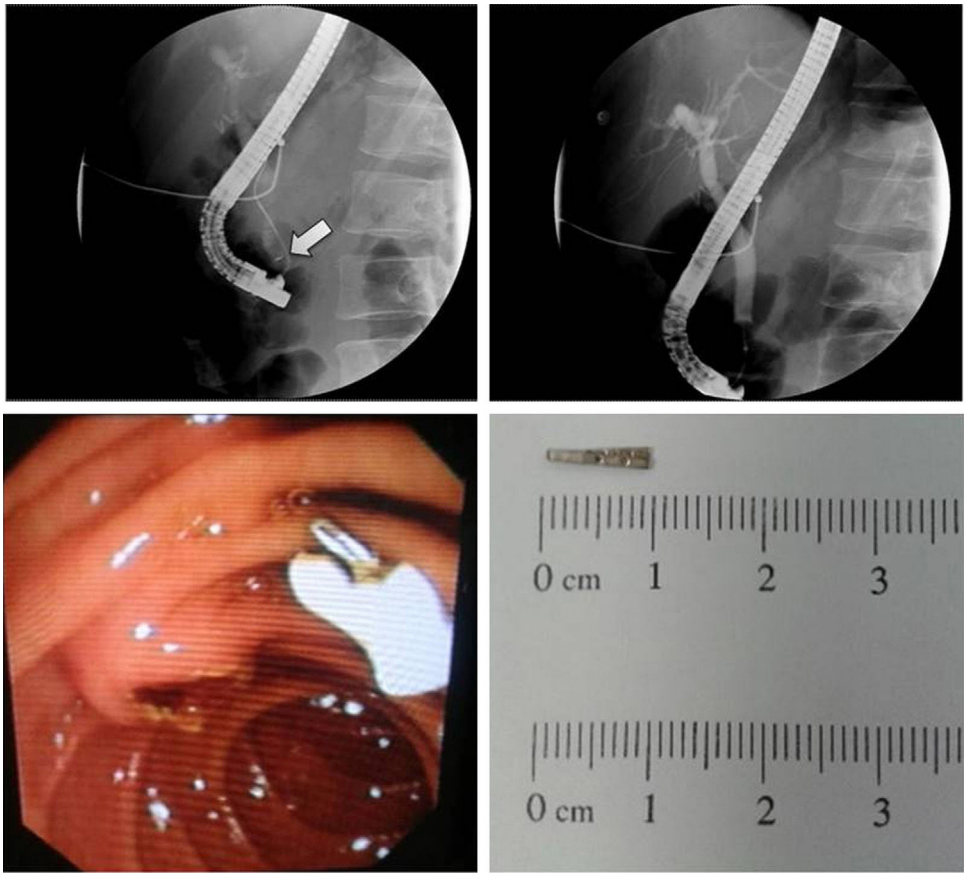

Figure 2 ERCP showing ductal dilatation secondary to an occluding surgical clip.

pathophysiological mechanism. In literature there are reports of endoclip migration into the common bile duct leading to stone formation, obstruction, cholangitis, stenosis and pancreatitis.[1] In the absence of guidelines, from literature reports and our own experience, we consider that an ERCP should be deliberated as the first approach, since almost all cases are solved with sphincterotomy and surgery should be reserved to the unsuccessful procedures.[1–5] Nevertheless, a previous multidisciplinary discussion with surgeons should be performed when managing this type of pathology.

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Primary hepatic leiomyoma: A rare liver mass☆

Leiomioma hepático primario: una rara causa de tumoración hepática

34-Year-old woman with a liver tumour found during a non-specific abdominal pain examination. History of oral contraceptive use and physical examination, with no palpable abdominal mass. The abdominal ultrasound revealed a solid vascularised mass, with no calcifications, measuring 85 mm in the IV segment of the left lobe of the liver. The assessment was completed with magnetic resonance imaging (MRI), evidencing an encapsulated lesion with well-defined edges, with T1 homogeneous signal and T2 and T2-STIR hypointense signal, emphasising a small site of greater intensity within the lesion in T2 (Fig. 1). After the injection of the contrast medium, filling of the early and late arterial phases of the tumour occurred, suggestive of hepatic adenoma. The blood tests, including liver function and tumour markers (AFP, CEA and CA 19.9), were normal. In light of the suspected diagnosis of hepatic adenoma and the large size of the tumour, it was decided to perform surgery without conducting a biopsy due to the risk of bleeding. We made a large right subcostal incision, finding a tumour 10 cm in diameter in the IVb segment of the liver, with 70% of its surface free. Tumour resection and cholecystectomy were performed. The anatomopathological study confirmed the diagnosis of a smooth muscle neoplasm with a mitotic index below one mitotic figure/10 fields. The immunohistochemical analysis confirmed positivity for Ki-67 below 1% and positive nuclear staining for oestrogen and progesterone receptors (Fig. 2). After the histological result, a pelvic ultrasound was performed to rule out uterine fibroids, as well as an abdominal computerised axial tomography (CT scan) to rule out gastrointestinal stromal tumour (GIST).

Leiomyoma is a benign smooth muscle mesenchymal tumour of uncertain malignant potential, which tends to manifest in the genitourinary system and the gastrointestinal tract.[1,2] However, it may also arise in the *muscularis mucosae* of the gastrointestinal tract or in the tunica media of the blood vessels, meaning that it could manifest in any organ or tissue of the human body.[3] Primary hepatic leiomyomas (PHLs) are rare tumours that predominantly affect girls and women, with reported cases in both children and adults alike.[1] Only 36 cases have been published to date in the scientific literature. The aetiology is not

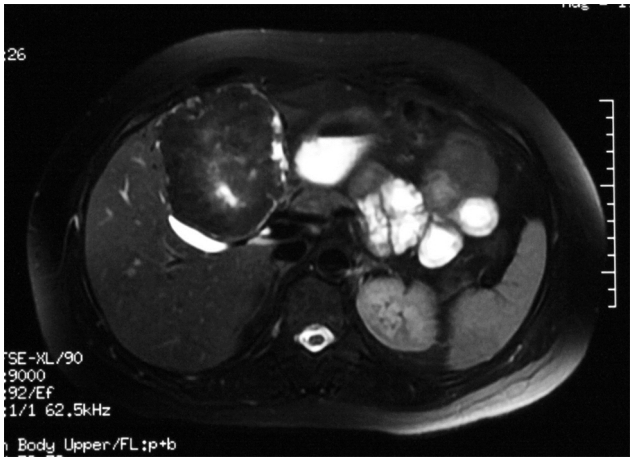

Figure 1 T2-weighted enhanced axial MRI image. Well-defined hypointense lesion with areas of hyperintensity in the IV segment, compressing the gallbladder.

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