ABSTRACT

A diagnosis of cystic lesion of epigastrium is challenging without strong evidence from history and physical examination. A 33-year-old lady has an epigastric mass without hepato-pancreaticobiliary symptoms, was unable to be diagnosed through radiological assessment and biochemical markers. She was diagnosed with hepatobilie cystadenoma through intraoperative assessment. We present a case of biliary cystadenoma with diagnostic challenge.

Key Words: Computed tomography, cystadenoma, hepatectomy, diagnostic imaging

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INTRODUCTION

A diagnosis of cystic lesion of epigastrium proves to be an undoubted challenge. History alone is scanty unless patient has other underlying history of chronic liver disease or pancreatitis. Physical examination might be limited especially in small lesions. Hence the diagnosis is usually supported by radiological findings.

Although ultrasonography is widely used, it is limited especially in localizing the origin and relation to the surrounding structures in view of operator dependent (1). At present, computed tomography (CT) is the primary choice for assessment of intra-abdominal masses. However, it does come with certain limitations, which can be daunting. Magnetic resonance cholangiopancreatography (MRCP) is another useful radiology imaging for assessment of intraabdominal cystic lesion. We are presenting a case of 33-year-old lady presented with cystic lesion at the epigastrium in which despite abdominal CT, the diagnosis remains elusive and doubtful.

CASE REPORT

A 33-year-old lady presented with persistent epigastric discomfort with mass for two months. She had no symptoms suggesting of gastric outlet or intestinal obstruction. No significant gynaecological or previous medical history identified. She denied taking oral contraceptive pills. Clinically, she was neither pale nor jaundice. There were absences of stigmata of chronic liver disease. A firm, non-tender, ill-defined mass occupying the epigastric region felt. It measured 5 cm below the subcostal margin. No ascites was detected. Other systems were unremarkable.

Hematologic and biochemical investigations were unremarkable. Tumour markers were also within normal range. CT scan of the abdomen demonstrated a huge solitary multiloculated cystic mass measuring 10 x 10 x 7 cm (Figure 1). The origin of the lesion was not clearly identified as no definitive plane was seen between the liver and pancreas.
The liver was non-cirrhotic. Endoscopic ultrasound (EUS) was performed and suggestive of pancreatic body mass. Since CT scan and EUS had a contradicting finding, diagnostic laparoscopy with definitive surgery was decided. The surgery revealed a cystic mass arising from left lobe of the liver. Pancreas was normal and free from the lesion. Hence, left hemi-hepatectomy was performed.

**CONCLUSION**

The aim for radiology is to determine the extension of the lesion rather than as a sole diagnostic tool. It will subsequently influence choice of surgical intervention as well as patient’s future outcome.

**Conflict of interest**

No conflict of interest was declared by the authors.
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