Case Report

Biloma a pseudocyst mimic

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INTRODUCTION

Bilioma is defined as an encapsulated collection of bile inside or outside of the biliary tree within the abdominal cavity. We report a case of a 56 years old male presented with complaints of abdominal distention and abdominal pain for 1 month whom on initial imaging, a diagnosis of pseudocyst of pancreas was suspected but on further imaging with MRCP, a biloma formation was found. Intervention involving Hepatobiliary tree is the most common etiology of a biloma formation. Biloma can also be caused by abdominal trauma and choledocholithiasis. In terms of treatment, small and uncomplicated cases need no intervention as spontaneous resolution is expected and in severe cases a combined approach using percutaneous drainage of biloma and endoscopic retrograde cholangiopancreatography (ERCP)-guided biliary stent placement across the site of the biliary leak or surgical hepaticojejunostomy or just image guided percutaneous drainage alone would be the treatment choice. Biloma should be included in the differential diagnosis of a large cystic lesion of the abdomen.

Keywords: Bilioma, Spontaneous bile leak, Complications of hepatobiliary interventions, Percutaneous drainage, Pseudocyst mimic

Table 1: Sensitivity of investigations.10

| Variables                  | Percentages (%) |
|----------------------------|-----------------|
| USG                        | 70              |
| CT                         | 90              |
| MRI                        | 95              |
| Hepatobiliary iminodiacetic acid (HIDA) | 97 |

HIDA is the diagnostic investigation of choice in Spontaneous bile leak cases.11 In terms of treatment, small and uncomplicated cases need no intervention as spontaneous resolution is expected and in severe cases a combined approach using percutaneous drainage of biloma and ERCP-guided biliary stent placement across the site of biliary leak or surgical hepaticojejunostomy or just image guided percutaneous drainage alone would be the treatment choice. Drainage of biloma may take 2-3 months. We herein present a rare case of biloma presenting as a cystic mass involving almost all quadrants of abdomen in a 56 years old male patient.
CASE REPORT

A 56 years old male was referred from another hospital to our casualty with complaints of abdominal distention, abdominal pain and vomiting for a duration of 1 month, history of loss of appetite was present, history similar illness a year ago was also present. Patient denied history of altered bowel habits, micturition abnormalities, fever, abdominal trauma and prior abdominal surgeries. Patient had no known comorbidities. Patient was a known smoker and alcoholic for 20 years. Clinical examination of the patient revealed a 15×10 cm cystic mass predominantly involving epigastric and periumbilical region extending 1 cm below xiphoid process to 3 cm below umbilicus. Laboratory workup was significant for elevated urea and creatinine levels (urea-111; creatinine-2.9).

Table 2: Investigations before percutaneous drainage.

| Parameters      | Variables |
|-----------------|-----------|
| WBC             | 11900     |
| HB              | 10.4      |
| PLT             | 4.211     |
| Urea            | 111       |
| Creatinine      | 2.9       |
| Total bilirubin | 0.8       |
| Direct bilirubin| 0.6       |
| SGOT            | 14        |
| SGPT            | 10        |
| ALP             | 108       |
| Total protein   | 8.3       |
| Albumin         | 3.5       |
| Serum sodium    | 132       |
| Serum potassium | 4.3       |
| Amylase         | 36        |
| Lipase          | 11        |

Note: On admission, patient had elevated renal parameters which normalized with adequate hydration (a).

Complete blood count, liver function test and serum electrolytes, amylase and lipase were unremarkable. Ultrasound abdomen and pelvis revealed an 18×10 cm cystic lesion, probably pseudocyst of pancreas, contracted gallbladder, echogenic sludge in gallbladder. CECT abdomen and pelvis revealed large lobulated thick-walled cystic lesion involving epigastrium and anterior pararenal space of size 17×9 cm, pancreas appears atrophic with multiple calcifications in body and head, dilated CBD with upstream dilation of biliary system and intrahepatic biliary radicals’ dilation.

MRCP of the patient revealed a large walled off intraperitoneal collection with debris and air pockets measuring 17×15×4.7 cm extending from gallbladder fossa encasing the gallbladder and extends into greater omentum at subhepatic space, epigastric and umbilical region—could represent biloma, dilated CBD 14 mm with debris within and chronic calcific pancreatitis with no obvious site of bile leak was found.

Patient was taken up for USG guided drainage of the collection. A 10 Fr Pigtail catheter was inserted and the first day output was 800 ml. Subsequently the patient had a constant daily output of 300 ml for 28 days. Then for 3 days patient output started declining gradually and became Nil output for 2 days and pigtail was removed.
Biloma is a rare medical condition. Biloma should be included in the differential diagnosis of a large cystic lesion of the abdomen. A combined approach of image guided biloma drainage and ERCP guided stenting across the site of bile leak have higher complete resolution rate than either approach alone. USG guided percutaneous drainage alone is an affordable option with excellent results.

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