

Metastases until proven otherwise

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Case description

A 65-year old woman was under hepatologic follow up for nonalcoholic steatohepatitis. She had impaired glucose tolerance with hyperinsulinism, dyslipidemia, visceral fat accumulation with BMI of 25,5 kg/m² and arterial hypertension. Biopsy in 2011 showed macro- and microvesicular steatosis and mild siderosis, with a NAS score of 4. There was slight perisinusoidal fibrosis with score F1A.

In 2017 she was diagnosed with ductal mammary carcinoma treated with tumorectomy and adjuvant radiotherapy. Ultrasound of the liver on routine hepatologic follow up 6 months later showed a heterogeneous parenchyma and an irregular surface. Shear-wave elastography values were high (mean 18,6 kPa), in accordance with cirrhosis (Fig 1A). Transaminases were mildly elevated with AST 37 IU/L (<31 IU/L) and ALT 40 IU/L (<34 IU/L), as was gamma-GT of 66 IU/L (<40 IU/L). Alkaline phosphatase, bilirubin and INR were normal. Viral and auto-immune serology was negative. MRI showed a slightly enlarged liver with pseudocirrhosis due to miliary opacities, with innumerable lesions of variable size (Fig 1B).

Surgical wedge biopsy was performed. Macroscopical appearance of the liver showed diffuse white-grayish nodules throughout the parenchyma (Fig 2A). On histological exam there were dilated bile duct structures lined with cuboid epithelium embedded in fibrous stroma and containing bile concretions (Fig 2B) and macrovesicular steatosis.

What is the diagnosis?

Imaging and histopathology are consistent with multiple Von Meyenburg Complexes or bile duct hamartomas. These common (5.6% on autopsy reports) benign congenital fibrocystic liver lesions present as small (<10mm) nodules and are part of the spectrum of ductal plate malformations. They are usually asymptomatic and cause no liver enzyme elevation or signs of liver dysfunction. Cholangitis, portal hypertension and non-specific abdominal discomfort are described as clinical manifestations. The differential diagnosis includes microabscesses, peliosis hepatis, miliary metastasis, Caroli's disease and diffuse hepatocellular carcinoma.

In this oncological setting, diffuse metastases should absolutely be ruled out. MRI image was not sufficient

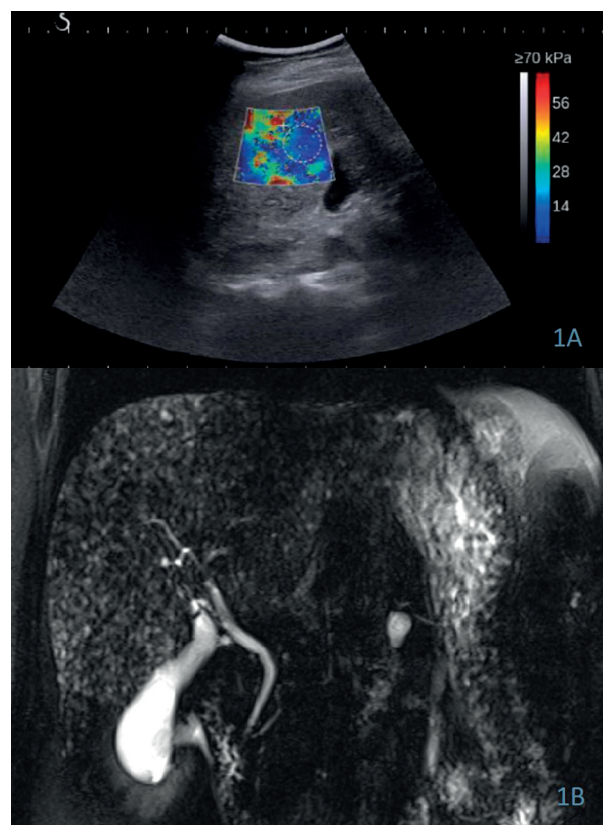


Figure 1. — A : Ultrasound with heterogeneous parenchyma and high shear wave elastographic values. B : MRCP image of innumerable hyperintense lesions without connection to the bile ducts.

to make a definite diagnosis. Needle biopsy carries a substantial risk for sampling error. The macroscopic aspect of the liver was also not conclusive. As in many cases, pathology was needed to make the definite diagnosis in order to give appropriate care.

Over the last 12 months, the patient's MRI image remains stable. Biannual follow up is offered because of growing evidence for the possible risk of malignant transformation to cholangiocarcinoma.

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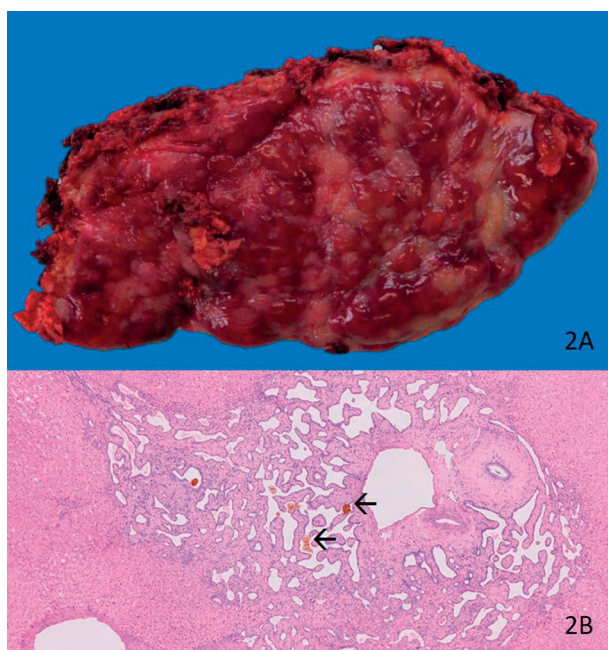


Figure 2. — A : resection specimen showing diffuse nodularity of liver parenchyma. B : Dilated bile duct structures containing bile-stained granular material (arrow).

Conflict of interest disclosure

All authors disclose no financial relationships or other conflicts of interest relevant to this publication