Extrahepatic cholangiocellular carcinomas are relatively rare malignant tumors. Although recent years have seen advances in diagnosis and treatment, cholangiocellular carcinomas are usually clinically silent or associated with nonspecific symptoms in the early stages; therefore, most tumors are diagnosed late, when they are inoperable [1]. The diagnosis can be especially challenging in patients with chronic cholangitis or previous hepatobiliary and pancreatic surgery.

We report an unusual case of a 49-year-old woman who presented with painless jaundice. In the past half year she had experienced loss of appetite and weight. Preoperative imaging including magnetic resonance imaging, magnetic resonance cholangiopancreatography (MRCP), endoscopic retrograde cholangiography (ERC), and computed tomography suggested cholangiocellular carcinoma (Bismuth type II/IIIb) (Figs. 1, 2). Brush cytology at ERC was not meaningful but a granulomatous tumor at the hilum with retained nonabsorbable sutures was found intraoperatively (Fig. 3). The final histological examination yielded a benign disease described as periductular fibrosis and chronic inflammation. Following a biliopancreaticoenteric anastomosis, the patient’s status improved uneventfully (Fig. 4). A retrospective review revealed an iatrogenic bile duct injury sustained during laparoscopic cholecystectomy 9 years previously, with end-to-end repair carried out in the same session. The patient was unaware of the earlier iatrogenic lesion.

Preoperative findings can suggest malignancy even in benign disease. Correct diagnosis will depend on a careful preoperative diagnostic workup including a detailed history, with special attention to previous surgeries. Definitive diagnosis will usually require surgical exploration, as chronic biliary inflammation or obstructive cholestasis is a known risk factor for cholangiocellular carcinomas. Nonetheless, up to 15% of suspicious tumors are benign lesions [2, 3]. Long, benign bile duct strictures are repaired with a biliopancreaticoenteric anastomosis (Fig. 4) but they do not require extended lymphadenectomy, which is associated with increased morbidity. The long-term results of biliopancreaticoenteric anastomosis for benign strictures are promising [4].

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References

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Fig. 4 Intraoperative view following bilio-digestive anastomosis.

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