EDİTÖRE MEKTUPLAR
LETTERS TO THE EDITOR

The giant choledochal cyst

Dev Koledok kist

Dear Sir,

Choledochal cysts are an uncommon anomaly of the biliary system manifested by cystic dilatation of the extra-or intrahepatic biliary tree or both, occuring in appoximately one of 2 million live births. They occur uncommonly but a higher incidence has been reported in Asians (1). Accurate preoperative morphologic information is available through a number of imaging modalities. But the size of the cyst may sometimes obscur the accurate diagnosis and delay the only option for treatment, the surgery. We report here a case of giant choledochal cyst.

The patient is an eighteen-year old girl who was admitted to the hospital with intense pain in her right upper abdominal quadrant along with nausea and vomiting. At that time there was jaundice and right upper quadrant mass with an elevation of ALT, AST, Alkaline phosphatase, gGT levels in the blood. Bilirubin levels both in the blood and urine were also elevated significantly. She was treated by many centers with different diagnosis. After the admission, ultrasonography (USG) of the abdomen was performed and found out a mass of 20x16x10 cm in sizes extending from inferior part of the liver to the right iliac fossa. Thereafter percutaneous transhepatic cholangiography (PTC) was performed and reported a choledochal cyst of 10x15 cm in sizes located on the superior part of the cystic duct. The computerized tomography (CT) and the endoscopic retrograde cholangiopancreatography (ERCP) revealed the common bile duct and pancreatic duct, although displaced considerably by a cyst, were joined to each other to form a common channel of 2.6 cm long (Fig. 1). The pancreatic duct was dilated at its level just proximal to the join. Then spiral CT was performed and the 3-D view was obtained (Fig. 2). In the operating room the cyst was measured as 20x18x16 cm.

The patient underwent cyst excision and Roux-en-Y hepaticojejunostomy. Multiple liver biopsies are obtained. In the postoperative period no complication was detected. The histopathologic work revealed choledochal cyst and precirrhotic liver disease. The patient is still quite well, entirely free of symptoms.

The estimated incidence of choledochal cyst disease ranges from 1 in 13000 to 1 in 2 million patients. Choledochal cysts are three to four times more common in females than in males. The majority of patients in whom it has been reported are children (2,3).

Alonso-Lej et al developed a classification system based on the anatomic description that was subsequently modified by Todani et al in 1977 and it's this system of classification that is in use today (4). There are reported patients who had an unusual choledochal cyst that does not conform to any of the described types. But these are a combination of two or more types according to the classification of Todani et al (5,6).

The classical clinical triad is abdominal pain, jaundice and a right hypochondrial mass. This triad has been reported mostly in children. But both children and adults were much more likely to have one or two of the classical symptoms. In adults clinical features are often atypical (4).

Complications mostly seen in adult age group are recurrent cholangitis, pancreatitis, duodenal obstruction, obstructive jaundice, portal fibrosis, perforation, lithiasis, biliary stricture, biliary cirrhosis, portal hypertension, malignancy, sepsis, intrahepatic abscess.

Malign degeneration is an important complication depending on the age of the patient and the type of surgical intervention (2). The risk of cyst associated cancer increases with age from 0.7 per cent in

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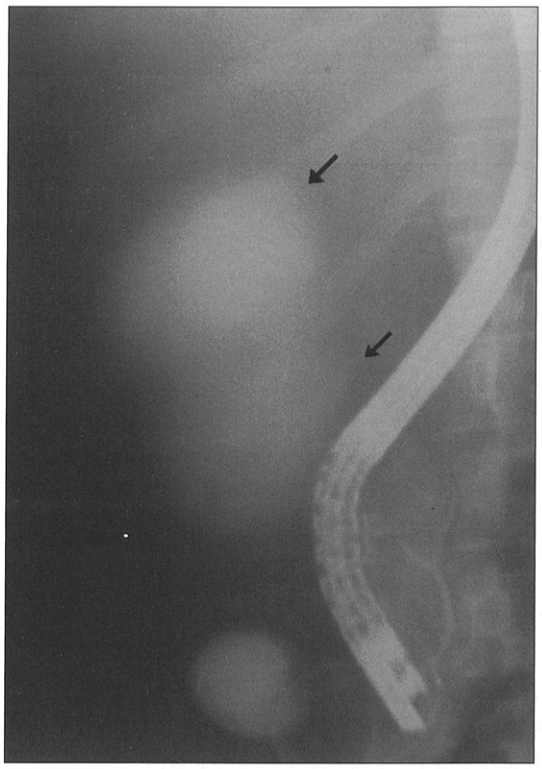

Figure 1. *The endoscopic retrograde cholangiopancreatography of the giant choledochal cyst.*

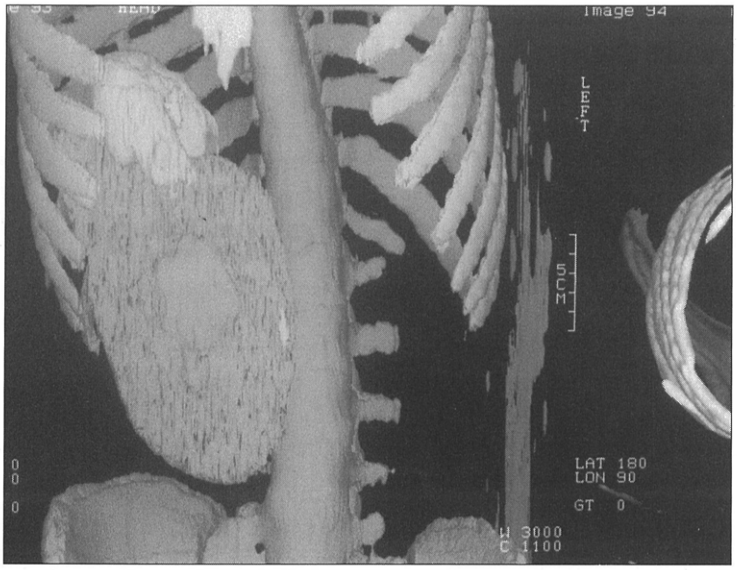

Figure 2. *View of the choledochal cyst in spiral CT.*

the first decade of life to 14.3 per cent after 20 years, further emphasizing the need for early diagnosis and treatment. In those who have had undergone enteric drainage without cyst excision, the incidence of carcinoma is 17.5 per cent (3,7). The average time gap for these patients is 10 years. It must also be noted that hepatobiliary malignancy in patients with a choledochal cyst is neither always intracystic nor prevented completely by cyst excision (2).

Dilated biliary ducts in connection with appropriate clinical signs and symptoms are an indication for surgery (5). Surgical excision and biliary reconstruction is now considered to be the treatment of choice for choledochal cysts. The type of surgical procedure in choice depends mostly on the type of the cyst, its anatomical properties, developed complications, the age and general status of the patients (8).

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Tirotoksikozda karaciğer sirozu gelişir mi?

Sayın Editör,

Türk Gastroenteroloji Dergisinin 1995 yılı 4. sayısında Sayın Dağlı ve ark.'nın (1) sundukları "Hipertiroidide kolestatik sarılık" başlıklı olgu bildirisinin giriş bölümünde "Otopsi çalışmalarında tirotoksikozda hepatik inflamasyon, nekroz ve siroz geliştiği bildirilmektedir" ifadesi yer almakta olup, kaynak olarak 1933 ve 1940 yılında yayınlanmış iki makale gösterilmiştir (2,3).

Gerçekten de 20. yüzyılın ilk yarısındaki yayınlarda tirotoksikozlu olgularda karaciğerde iltihabi reaksiyon, yağlı değişiklikler, nekroz ve siroz tanımlanmıştır. Tirotoksikoz ile birlikte karaciğer sirozu olgularına ilişkin en eski raporlardan biri Marine ve Lenhard tarafından 1911 yılında bildirilmiş olup, otopside 6 olgunun 4'ünde siroz saptanmıştır (4). 1933 yılında Beaver ve Pemberton, 107 olguyu kapsayan araştırmalarında tirotosikozla ilişkili olarak üç tipte hepatik lezyon oluştuğunu öne sürmüşlerdir (5); 1) akut dejeneratif değişiklikler (yağlanma, fokal ve santral nekroz, staz) 2) basit atrofi ve 3)subakut toksik atrofi ve toksik siroz. 1935'de Camerun ve Karuntaratne de benzer bulguları tanımlamışlardır (6). 1946 yılında ise Moschcowitz, 31 olgunun 11'inde siroz saptadığı çalışmasında tirotoksikoza özgü bir siroz tipinin varlığından bahsetmiştir (7).

Fakat daha sonraki raporlar tirotoksikozda karaciğerdeki değişikliklerin pek anlamlı olmadığı yönündedir. 1947 yılında Piper (8), 1953 yılında ise Movitt ve akadaşları (9) tirotoksikoz olgularının karaciğer biyopsilerinde anlamlı patolojik değişiklikler saptamamışlardır. Keza 1971'de Klion ve arkadaşları da benzer sonuçlar elde etmişlerdir (10). Hipertiroidi olgularında saptanan hepatik lezyonlar tiroid hormonlarının karaciğere direkt etkisinden ziyade kalp yetersizliği, infeksiyon, hipoksi ve malnutrisyon gibi ikincil nedenlere bağlanmaktadır (11,12).

Adı geçen yazıda hipertiroidiye eşlik eden kolestaz olguları sunulmasına karşın giriş bölümünde tirotoksikozda siroz geliştiğine dair ifadenin yer alması, yanlış anlaşılmalara yol açmaktadır.

Tirotoksikoz ile birlikte karaciğer sirozu olguları ancak yüzyılın ilk yarısında bildirilmiş olup Moschcowitz'in 1946 yılındaki raporundan sonra literatürde olgu sunumu yoktur. Gerçekten de eskiden otopsi raporlarına ilişkin yayınlarda böyle bir sav olmasına karşın bugün artık bu görüş dışlanmaktadır (13-16). Bu nedenle henüz daha hepatit virüsleriyle tanışılmadığı dönemlere ilişkin literatür verilerine dayanarak tirotoksikozda karaciğer sirozu geliştiği savının oldukça iddialı olduğu kanısındayım. Bugün hipertiroidide karaciğer sirozunun gelişip gelişmediği artık tartışılmamaktadır. Bugünkü görüşe göre hipertiroidi, karaciğer sirozunun etyolojisinde yer almamaktadır (17,18).

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