A rare, incidental liver mass in an asymptomatic young patient: Inflammatory pseudotumor

Asemptomatik genç bir hastada insidental saptanan karaciğerin nadir kitlesi; inflamatuar psödotümör

To the Editor,

A 24-year-old male patient with a complaint of bilateral flank pain had been admitted to a hospital providing secondary care. In the urinary system ultrasonography, a thick-walled spherical cystic lesion was initially evaluated as an abscess, and the patient was referred to the interventional radiology clinic of our hospital for an advanced evaluation and treatment. The patient was referred for abscess drainage, but his medical history was incompatible with an abscess. His physical examination and vital signs were normal. Laboratory evaluations were within normal range except for

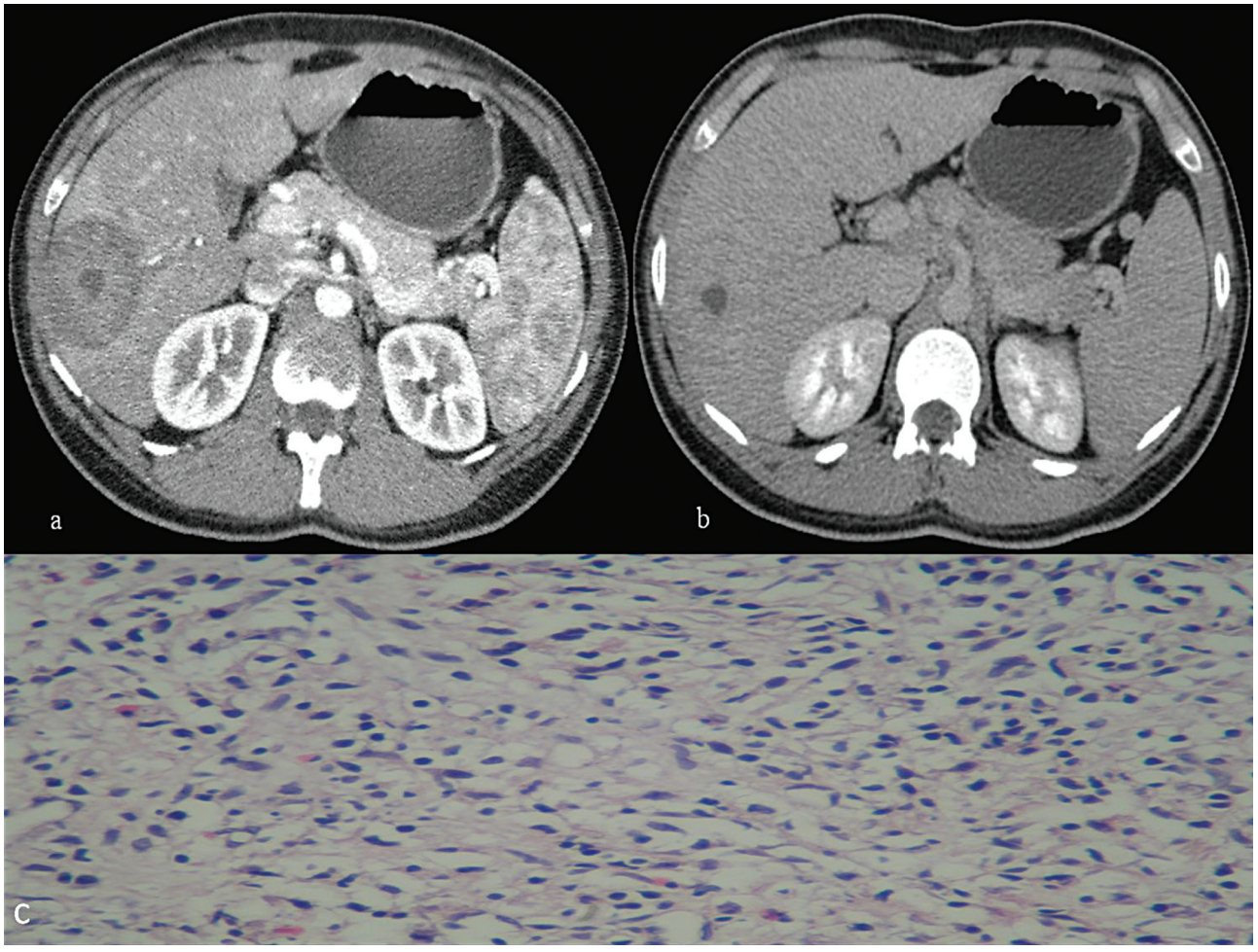

Figure 1 (a, b, c). Axial post-contrast CT images show, as a target sign, contrast enhancement of the mass in the arterial phase **(a);** in the late venous phase, the mass and liver are isodense **(b);** and in the magnified histopathological picture, proliferated spindle cells without atypical morphology, lymphocytes, histiocytes, and eosinophils are observed **(c)** (H&E stain, X400).

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high C-reactive protein (CRP, 15 mg/dl), erythrocyte sedimentation rate (ESR, 62 mm/hour) and alanine aminotransferase (ALT, 45 U/L). Multi-slice computed tomography (CT) and magnetic resonance imaging (MRI) showed a thick-walled spherical mass containing centrally cystic areas and smooth margins, without evidence of peripheral invasion, in segment 6 of the posterior right hepatic lobe (Figure 1). Due to atypical CT and MRI findings, percutaneous biopsy of the mass was performed. Inflammatory pseudotumor (IPT) was diagnosed based on the histopathological findings. Treatment with antibiotic (cefuroxime axetil 500 mg) and anti-inflammatory (naproxen sodium 550 mg) drugs was ordered for two weeks. At the follow-up visit at the end of the first month, the mass was 60-70% smaller, and the borders of the mass were less apparent on ultrasonography.

Hepatic IPT is an idiopathic, rare, benign, and tumor-like lesion. It is a granulomatous reaction containing plasma cells, chronic inflammatory cells and sometimes histiocytes around a fibrous stroma (1), and it is usually seen in the lungs. Involvements of the orbita, oral cavity, parotid gland, pleura, liver, stomach, ovary, and retroperitoneum have been reported in the literature less frequently (2). The etiology of IPT is still unknown; infections, autoimmunity and biliary obstruction are the known possible causes. It is more common in males, and the average age of onset is 35 years (3-5).

Clinical symptoms of IPT are fever, epigastric pain, vomiting, general weakness, weight loss, and jaundice. Leukocytosis and increased ESR may be seen (4,5). In the differential diagnosis of IPT from other tumors, one of the most important findings is negative tumor markers, which was valid for our patient as well (5). The mass was diagnosed incidentally in our case. Except for higher levels of CRP and ESR in our case, there were no clinical symptoms or abnormal laboratory findings. As a result, although IPT is usually symptomatic, in some rare cases, it may be asymptomatic and incidentally detected. If an atypical contrast pattern is seen in a mass of the liver, IPT should be kept in mind.

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Hepatitis A-associated immune thrombocytopenia

Hepatit A-immün trombositopeni birlikteliği

To the Editor,

Immune thrombocytopenia (ITP) is the most frequently encountered autoimmune disorder related with blood cells, and the acute form is generally seen in children following viral infection or vaccination. Epstein-Barr virus, parvovirus, human immunodeficiency virus (HIV), and hepatitis C

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