An Interesting Case of Cholangiocarcinoma Masquerading as Bile Duct Stones

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Introduction
Cholangiocarcinoma presents a formidable diagnostic and treatment challenge. The majority of patients present with unresectable disease and have a survival of less than 12 months following diagnosis. We present an interesting case of cholangiocarcinoma which was masked by choledocholithiasis/cholangitis.

Case Details
An 87-year-old white male with history of Non-Hodgkin's lymphoma in remission, COPD, and CHF presented with right upper quadrant abdominal pain, fevers, and jaundice for 4 days. Review of symptoms was positive for weight loss, pale stools, and dark urine. Patient had a 20-pack-year history of smoking and occasional alcohol. Vitals noted a fever of 101.2°F, BP 130/80, HR 104, RR 20, pulse ox 98% on room air. Physical exam was significant for scleral icterus and right upper quadrant tenderness. Labs revealed a white count of 17.4, platelets 55,000, bands 30, T-bili 3.0, D-bili 2.1, ALP 414, AST 90, ALT 74. Right upper quadrant US revealed a distended gallbladder with thickened wall and no pericholecystic fluid or gallstones. CBD was 10 mm with biliary sludge. IV antibiotics were started. Patient then underwent EUS and ERCP. EUS revealed mild dilation of the CBD and intrahepatic bile ducts along with multiple stones in the CBD. Repeat ERCP was performed 6 weeks later by another endoscopist, at which time the previously placed stent was removed. Repeat cholangiogram identified a high-grade localized biliary stricture at the level of common hepatic duct concerning for cholangiocarcinoma. Stricture was dilated and brushed and a stent was re-inserted into the CBD. Cytology was interpreted as abnormal with groups of atypical glandular cells seen. MRCP was then performed which revealed irregular intra- and extrahepatic biliary dilatation with abrupt narrowing of the common duct in the region of the porta hepatis. There was vague enhancement present in the liver in the region of the porta hepatis near the confluence, suspicious for cholangiocarcinoma. Patient was also noted to have an elevated CA19-9 of 485. Patient refused any surgery or chemotherapy given his advanced age and multiple comorbidities and opted for palliative care. He ultimately underwent a third ERCP, at which time a palliative metal biliary stent was placed.

Conclusion
• Choleodocholithiasis and cholangiocarcinoma can be found simultaneously in a patient during ERCP.
• Endoscopists should be sure to perform a thorough cholangiogram to exclude alternative/concomitant diagnoses.
• Imaging modalities such as MRCP to evaluate intrahepatic ductal or proximal CBD lesions should be considered as it complements EUS and ERCP.

References