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CLINICAL CASE

Inflammatory pseudotumor of the liver. Importance of intraoperative pathology☆

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KEYWORDS
Inflammatory pseudotumour;
Hepatic neoplasms;
Fever of unknown origin

Abstract
Background: Inflammatory pseudotumour is a rare entity, considered benign, and characterised by inflammatory cell mesenchymal proliferation.
Clinical case: The case is presented 70-year-old man with fever of unknown origin syndrome. He was diagnosed with liver abscesses (one segment IV, adjacent to gallbladder fundus and segment VI), who progressed slowly after antibiotic treatment. In the absence of a diagnosis, although fine needle puncture-aspiration and different imaging tests were performed, elective surgery was decided. The intra-operative histopathology reported the existence of an inflammatory pseudotumour.
Conclusions: Inflammatory pseudotumours are clinically classified into different types according to their aetiology, varying therapeutic management based on the same. It is very difficult to diagnose because of the absence of symptoms, blood disorders, or specific radiological findings. Definitive diagnosis often requires histopathological confirmation, in most cases by percutaneous liver puncture, but sometimes exploratory laparotomy or even performing a hepatectomy for confirmation is necessary. The natural history of inflammatory pseudotumour is its regression; thus conservative management may be used through regular checks until resolution, or can be treated with antibiotics, anti-inflammatories and even corticosteroids. Surgical

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resection is indicated for persistent unresolved systemic symptoms despite medical treatment, in those situations where growth is evident, with or without symptoms, when involving the hepatic hilum, and finally, in case where the possibility of malignancy cannot be ruled out.

PALABRAS CLAVE
Pseudotumor inflamatorio;
Neoplasias hepáticas;
Fiebre de origen desconocido

Pseudotumor inflamatorio hepático. Importancia de la anatomía patológica intraoperatoria

Resumen
Antecedentes: El pseudotumor inflamatorio es una entidad poco frecuente, considerada como benigna, caracterizada por la proliferación mesenquimal de células inflamatorias.
Caso clínico: Presentamos el caso clínico de un varón de 70 años con síndrome febril de origen desconocido, diagnosticado de abscesos hepáticos, que tras tratamiento antibiótico no mejoró. Se decidió realizar intervención quirúrgica ante la sospecha de cáncer de vesícula por imágenes de tomografía computada abdominal, reseñando la anatomía patológica intraoperatoria la existencia de un pseudotumor inflamatorio.
Conclusión: El pseudotumor inflamatorio está clínicamente clasificado en varios tipos según su etiología, variando las opciones de tratamiento en función de la misma. Es muy difícil su diagnóstico debido a la ausencia de síntomas o alteraciones hematológicas o radiológicas específicos. El diagnóstico definitivo requiere a menudo una confirmación histopatológica, en la mayoría de los casos mediante punción percutánea hepática, pero a veces es necesaria una laparotomía exploradora o incluso la realización de una hepatectomía para su confirmación. La historia natural del pseudotumor inflamatorio es su remisión, por lo que se puede llevar a cabo una actitud conservadora mediante controles periódicos hasta su resolución o se puede tratar con antibióticos, antiinflamatorios e incluso corticoides. La resección quirúrgica queda para la persistencia de síntomas sistémicos no resueltos a pesar del tratamiento médico, en aquellas situaciones en las que se evidencia crecimiento, con o sin síntomas, cuando está implicado el hilio hepático y, por último, en caso de no poder descartar la posibilidad de malignidad.

Background

The inflammatory pseudotumour is a very uncommon entity, regarded as benign, characterised by the mesenchymal proliferation of inflammatory cells, mainly lymphocytes, plasma cells and, occasionally, histiocytes.[1] It was first observed in the liver in 1953 by Pack and Baker.[2] Radiologically, in some cases, this entity may imitate malignant tumours, so its differential diagnosis is highly important.[3] It may appear on any part of the organism, the lungs being the most frequent location, although it has also been observed in the central nervous system, the eyes, the liver or the spleen.

This is the clinical case of a 70-year-old male patient with symptoms of low-grade fever and constitutional syndrome which presents 2 liver lesions indicating liver abscesses, as observed with an abdominal computer tomography.

Clinical case

This is the clinical case of a 70-year-old male patient with a personal history of penicillin allergy, high blood pressure, lung tuberculosis, diabetes, gouty arthritis, renal lithiasis and colon diverticulitis. The patient was admitted to his reference hospital due to clinical symptoms with a progression of at least 3 weeks involving low-grade fever, asthenia, anorexia, weight loss and oligoarthritis (of the knees and interphalangeal joints). The patient was in good general condition and his physical examination was normal. Laboratory tests show the presence of gamma-glutamyl transpeptidase 153 IU/l (8–61), alkaline phosphatase 142 IU/l (40–129) and total bilirubin 0.41 IU/l (0.05–1.1), with liver lysis enzymes within normal ranges. A test was carried out to rule out the presence of an infectious disease (human immunodeficiency virus, hepatitis B and C virus, cytomegalovirus, *Coxiella burnetii*, lues, Q fever, rose bengal and hydatidosis), which had a negative result, as well as of the presence of an immunological disease (antinuclear antibodies, antibodies extracted from the nucleus, anti-DNA antibodies, anti-endothelial cell antibodies), which also had a negative result. All the tumour markers (alpha-phetoprotein, CEA, CA19-9 and prostatic antigen) were negative. The echocardiography showed no signs of endocarditis. A sputum bacilloscopy and culture were conducted, and a negative result was obtained as well, as it occurred with the urine culture and colonoscopy. A