Thieme

Common bile duct polyp: an infrequent cause of jaundice and biliary obstruction

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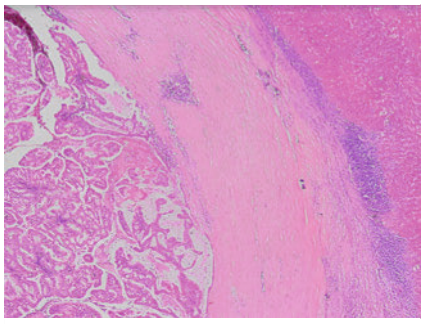
▶ **Fig. 1** Computed tomography showing circumferential thickening of the proximal common bile duct and left hepatic duct.

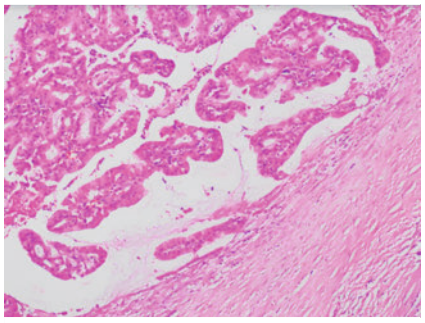
▶ **Fig. 2** Magnetic resonance cholangiopancreatography showing circumferential thickening of the proximal common bile duct and left hepatic duct.

The most common etiology of common bile duct (CBD) obstruction is bile duct stones; less common causes include biliary polyps and intraductal papillary neoplasm of the bile duct (IPNB). Initially described by Nakamura et al. [1] in 2010, IPNB is defined as a pedunculated mass with intraluminal growth exhibiting significant malignant potential that can subsequently lead to cholangiocarcinoma.

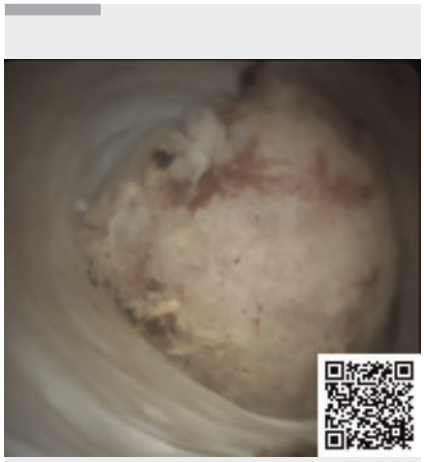
We present the case of a 75-year-old woman with a history of jaundice and mild abdominal pain. Computed tomography and magnetic resonance cholangiopancreatography showed circumferential thickening of the proximal CBD and left hepatic duct (▶ **Fig. 1**, ▶ **Fig. 2**).



▶ **Fig. 3** Histopathological image showing cubic monostratified papillary biliary epithelium and intraductal papillary neoplasia. Externally, a fibrous capsule delimits the liver tissue with an inflammatory infiltrate (hematoxylin and eosin, ×4).



▶ **Fig. 4** Histopathological image showing a papillary neoplasia with a fibrovascular core, as well as areas of high grade dysplasia in the gastric and pancreatobiliary epithelium, without evidence of invasive carcinoma (hematoxylin and eosin, 10×).



Video 1 Cholangioscopy showing a single, whitish papillary mass with a regular surface, located between the proximal common bile duct (CBD) and left hepatic duct.

Liver function tests confirmed a cholestatic pattern, with total bilirubin of 7.4 mg/dL, direct bilirubin of 5.3 mg/dL, alkaline phosphatase of 475 IU/L, and normal CA 19.9 level. Cholangioscopy revealed a single whitish papillary mass with a regular surface, located between the proximal CBD and left hepatic duct, obstructing approximately 80% of the biliary lumen (▶ **Video 1**). Multiple samples were obtained using SpyBite forceps (Boston Scientific, Marlborough, Massachusetts, USA). Histological analysis confirmed the presence of an IPND with high grade dysplasia (▶ **Fig. 3**, ▶ **Fig. 4**). The patient underwent left hepatectomy. The surgical specimen demonstrated a 17-mm lesion with biliopancreatic epithelium, involvement of the left hepatic duct, and no evidence of invasive carcinoma (▶ **Fig. 4**).

Biliary polyps are classified as IPNBs. Given their potential to cause obstructive jaundice and cholangitis, as well as a high malignant potential, IPNBs must be treated surgically [2, 3]. Our case under-

scores the value of performing cholangioscopy with targeted biopsies for the assessment and characterization of CBD tumors.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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