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Letter to the Editor

Xanthogranulomatous Cholecystitis Complicated by Large Hepatic Abscess: Letter to the Editor

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To the Editor,

Xanthogranulomatous cholecystitis (XGC) is an uncommon form of chronic cholecystitis characterized by the destructive accumulation of lipid-laden macrophages (xanthoma cells), fibrosis, and inflammatory infiltration. [1] While it often mimics gallbladder carcinoma both clinically and radiologically, rare cases may present with contiguous spread to adjacent organs such as the liver, leading to serious complications like abscess formation. [2] Early recognition is critical to guide appropriate management and avoid unnecessary radical surgery. [3]

A 90-year-old male presented with right upper quadrant abdominal pain, fever, and malaise. Laboratory investigations revealed mild leukocytosis and elevated inflammatory markers. Liver function tests showed mild cholestatic changes. Computed tomography (CT) scan showed markedly thickened and distended gallbladder with diffuse heterogeneous mural thickening. Hypoattenuating intramural nodules are present within the gallbladder wall. Adjacent liver parenchymal involvement with a large multiloculated enhancing lesion involving segments VIII and V, consistent with a hepatic abscess secondary to contiguous inflammatory extension with associated mild intrahepatic biliary ductal dilatation. **Figure 1** shows these features.

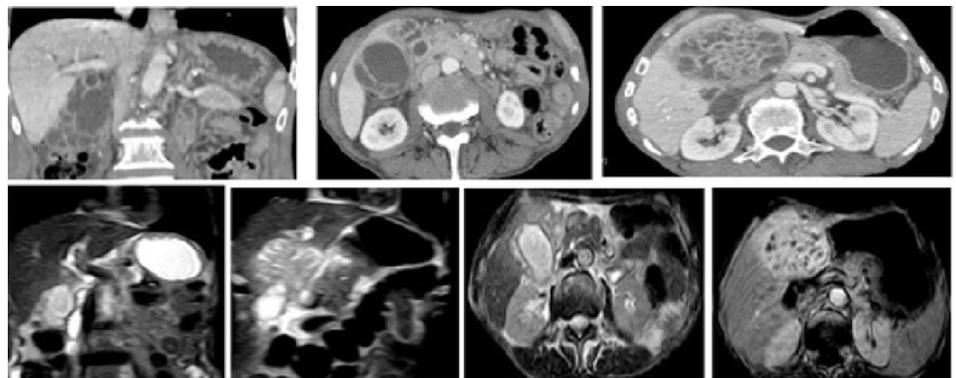


Figure 1: CT scan of the abdomen shows the gallbladder wall thickening with multiple high-signal intramural nodules. Delayed enhancement of the gallbladder, and a multiloculated large contrast-enhanced hepatic abscess.

The patient underwent percutaneous drainage of the liver abscess followed by laparoscopic cholecystectomy. Intraoperatively, the gallbladder was densely adherent to the liver with extensive inflammatory changes. Histopathology confirmed XGC with no evidence of malignancy.

XGC is a benign, locally aggressive inflammatory disease with an incidence of approximately 1.3% to 5.2% in cholecystectomy specimens. [4] XGC diagnosis and therapy are a dilemma for diagnostic radiologists, surgeons, and physicians. [5] Hepatic abscess formation due to contiguous spread from XGC is rare and can be a diagnostic challenge. [6] Features favoring XGC over carcinoma include: (A) Presence of intramural hypoattenuating nodules, (B) Preservation of the mucosal line, (C) Diffuse gallbladder wall thickening, and (D) Lack of overt discrete mass or distant metastasis. [7] In XGC cases complicated by liver abscess, timely intervention with drainage and appropriate surgical management is critical for patient recovery. Awareness of this rare complication can prevent misdiagnosis and guide optimal treatment. [8]

In conclusion, XGC should be considered in the differential diagnosis of gallbladder wall thickening, particularly when accompanied by adjacent hepatic lesions. Recognition of rare complications, such as liver abscess formation, is essential to optimize management strategies and improve patient outcomes.

PATIENT CONSENT

A written informed consent was obtained from the patient for publication of this case report.

AUTHORS' CONTRIBUTION

All authors contributed to the completion of this work. The final manuscript was read and approved by all authors.

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CONFLICT OF INTEREST

None.

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