Accessory Hepatic Lobe Attached To The Anterior Wall of Gall Bladder - A Rare Entity

Khalid Ibrahim.[1*] Baqir Hassan,[1] Sara Fatima,[1] Bushra Aman[1]

ABSTRACT

Accessory liver lobe is a rare anomaly found incidentally during laparoscopy, laparotomy or abdominal radiographic studies. It may be due to excessive liver development. Mostly it is infrahepatic. If it is pendunculated, patient may present with severe abdominal pain. We are reporting a female who presented with pain right hypochondrium, nausea and vomiting for the last three months with deranged liver function tests. Ultrasound abdomen showed cholelithiasis and nodular structure on anterior wall of gall bladder. CT scan abdomen revealed nodular structure arising from liver with same consistency over anterior wall of gall bladder. Cholecystectomy was done and nodular structure, the accessory liver lobe was resected. Histopathological report confirmed liver tissue.

Key words *Accessory liver lobe, Abdominal pain, Hepatoma.*

INTRODUCTION:

Accessory liver lobes are rare anomaly.[1]These are recognized incidentally during surgery or may present with severe abdominal pain due to torsion of its pedicle.[2] It may present as nodule or tongue like structure in the vicinity of gall bladder, or a separate structure attached to liver by its pedicle or mesentery, having blood vessels and bile ducts.[3]

CASE REPORT:

A 45-year old female admitted to surgical ward with the complaints of pain right hypochondrium, nausea, vomiting and yellow discoloration of eyes for the last three months. Her liver function tests showed bilirubin 27umol/l, Serum ALT 559u/l, and alkaline phosphatase 288u/l. Ultrasound abdomen revealed cholelithiasis and a nodular structure on the anterior wall of gall bladder. CT scan abdomen showed a well defined small soft tissue nodule having similar density and enhancing characteristics as that of liver, on the surface of gall bladder (Fig. I). Cholecystectomy was done and nodular structure was excised (Fig. II). Patient showed uneventful postoperative recovery. Histopathological report confirmed the removed structure as that of hepatic nature.

DISCUSSION:

Accessory liver lobe is a rare entity. It is usually

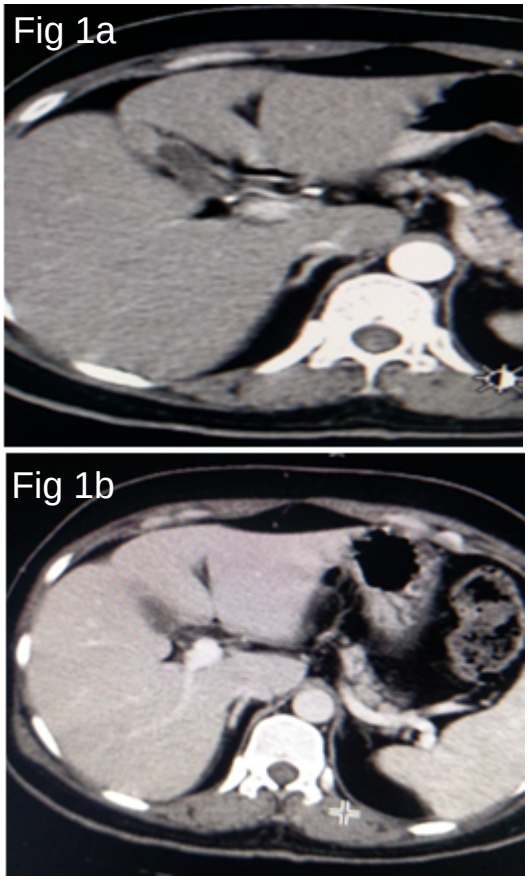

Fig: I a & b: CT scan abdomen showing accessory liver lobe as nodular structure

[1] Department of Surgery Combined Military Hospital Malir Cantt, Karachi

Correspondence:
Dr. Khalid Ibrahim [1*]
Department of Surgery
Combined Military Hospital Malir Cantt
Karachi
E-mail: khalidibrahimsurg@hotmail.com

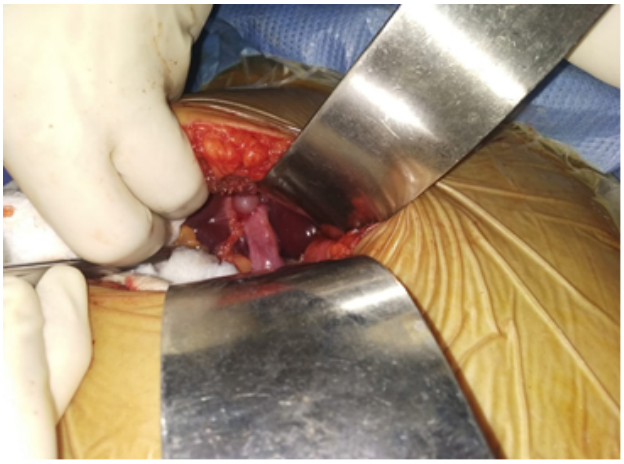

Fig II: Peroperative finding of liver nodule on surface of gall bladder

asymptomatic with incidental finding during surgery or at autopsy. Patients usually present with recurrent abdominal pain with deranged liver functions.[4] Usually it is infra-hepatic in position.[5,6] Accessory liver lobe on the basis of common capsule and biliary drainage are of three types: Type1 is accessory lobe duct draining into intrahepatic bile duct of normal liver, Type 2 the accessory lobe duct draining into extra hepatic bile duct of normal liver and Type 3 is accessory lobe, common capsule with normal liver, with bile duct of accessory lobe draining into extra hepatic duct.[7] It may present as severe pain due to pedicle torsion, bleeding, or suspected as a liver tumor.[8,9] Preoperative diagnosis is difficult but ultrasound abdomen, MRI, and CT scan may help in suspecting them.[2,10] Laparoscopic surgery is ideal for the diagnosis as well as treating the lesion.[11] Our patient had gall stones as well thus during surgery the lesion was removed with gall bladder and histopathology confirmed it as a structure resembling liver.

CONLUSION

Although it is rare entity but may present in emergency with severe abdominal pain. Its presence may be suspected when an abnormal lesion is noted on ultrasound abdomen in right hypochondrium.

REFERENCES:

1. Glenisson M, Salloum C, Lim C, Lacaze L, Malek A, Enriquez A, et al.Accessory liver lobes: anatomical description and clinical implications**.** J Visc Surg. 2014;151:451-5.

2. Carrabetta S, Piombo A, Podestà R, Auriati L. Images in surgery: Torsion and infarction of accessory liver lobe in young man. Surgery. 2009;145:448-9.

3. Yankol Y, Mecit N, Kanmaz T, Acaril K, Kalayoglu M. A very original case of a mini accessory liver lobe with its own gall bladder. Surg Radiol Anat. 2015; 37: 535-8.

4. Fogh J, Tromholt N, Jørgensen F. Persistent impairment of liver function caused by a pedunculated accessory liver lobe**.** Eur J Nucl Med.1989;15:326-7.

5. Kostov DV, Kobakov GL. Accessory hepatic lobe. Surg Radiol Anat. 2011;33:819-2.

6. Wang C, Cheng L, Zhang Z, Xie T, Ding H, Deng Q, et al. Accessory lobes of the liver: A report of 3 cases and review of the literature. Intrac Rare Dis Res. 2012; 1:86-91.

7. Elmasalme F, Aljudaibi A, Matbouly S, Hejazi N, Zuberi MS. Torsion of an accessory lobe of the liver in an infant.J Pediatr Surg.1995;30:1348-50.

8. Negru D, Tudorache C, Marinescu M, Grigora M, Crumpei F, Georgescu S.Torsion and infarction of an accessory liver lobe. Rev Med Chir Soc Med Nat Iasi. 2007;111:442-5.

9. Hundal RS, Ali J, Korsten MA, Khan AM. Torsion and infarction of an accessory liver lobe. Z Gastroenterol. 2006; 44:1223-6.

10. Stattaus J, Kühl H, Forsting M. Diagnosis of an accessory liver lobe established by magnetic resonance imaging-guided core biopsy. Z Gastroenterol. 2008; 46:351-4

11. Sommariva A, Pasquali S, Stramare R, Montesco M, Tropea S, Rossi CR, Laparoscopic diagnosis and treatment of a twisted accessory liver lobe. CRSLS. e2014.00170

Received for publication: 22-08-2019

Accepted after revision: 28-02-2020

Author's Contributions:
Khalid Ibrahim: Manuscript writing.
Baqir Hassan: Manuscript writing..
Sara Fatima: Manuscript writing..
Bushra Aman: Manuscript writing..

Conflict of Interest:
The authors declare that they have no conflict of interest.

Source of Funding: None

How to cite this article:
Ibrahim K, Hassan B, Fatima S, Aman B. Accessory hepatic lobe attached to the anterior wall of gall bladder - A rare entity. J Surg Pakistan. 2019;25(2):93-95. Doi:10.21699/jsp.25.2.10.