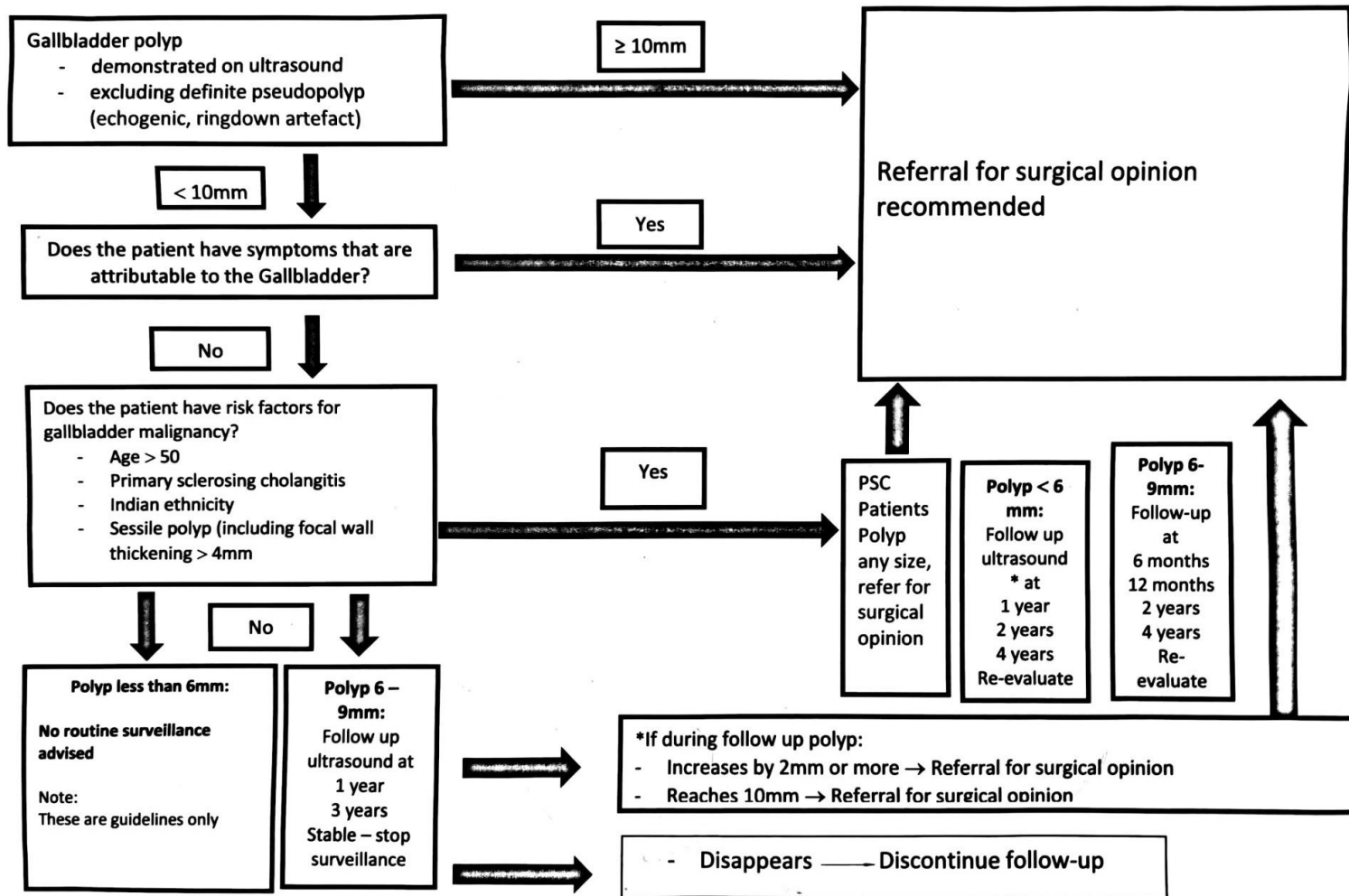


Auckland Guidelines for management GB polyps

(Updated 2021)



Case 3: Mrs L 38yo ♀ accountant

- Upper abdominal discomfort after meals
- Normal liver tests
- USS showed a 5mm hyperechoic lesion in segment 7, consistent with haemangioma

Which of these are risk factors for hepatic malignancy requiring further investigation?

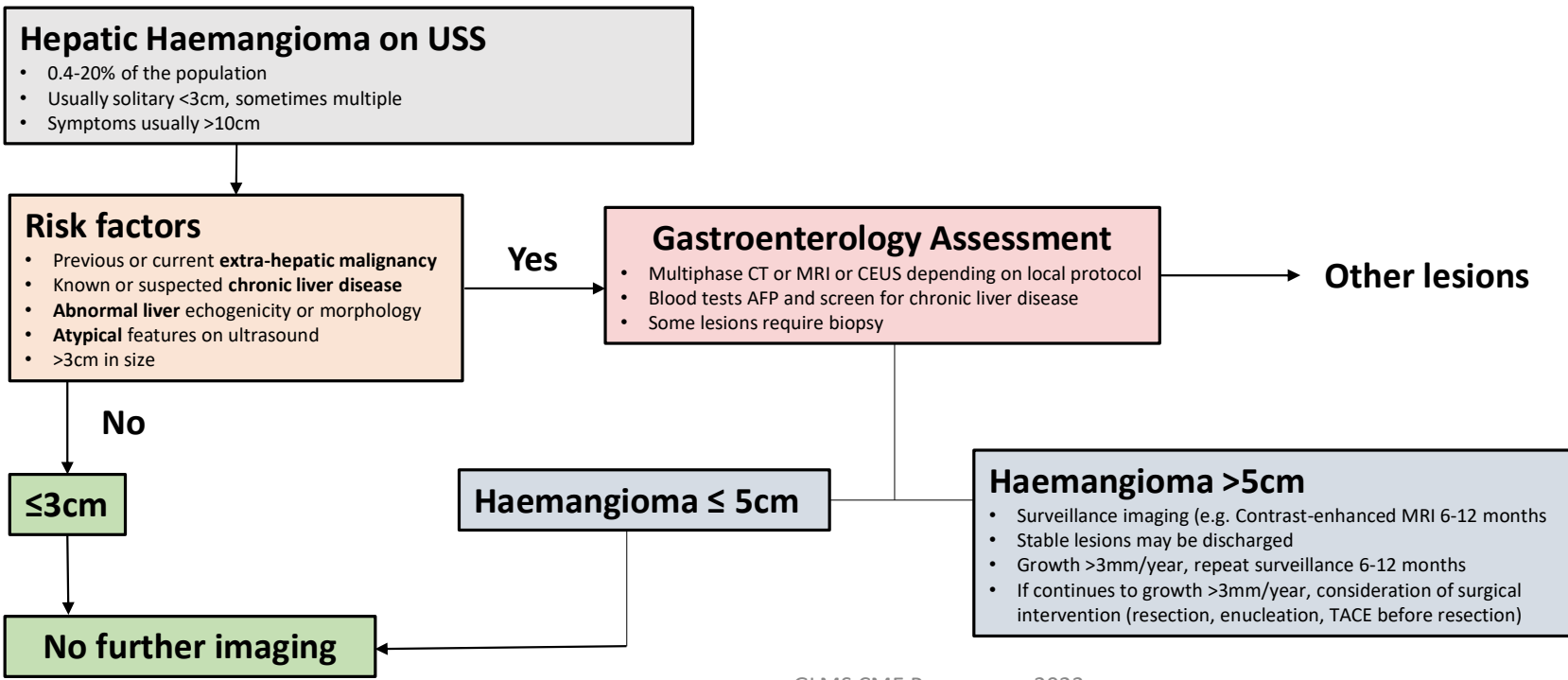
- A) Previous or current extra-hepatic malignancy
- B) Deranged liver function tests
- C) Abnormal liver echogenicity or morphology on USS
- D) Atypical features for haemangioma on USS
- E) Clinically known or suspected chronic liver disease
- F) All of the above



Liver lesions

- Increasingly **common** with use of imaging,
- Most benign, but often need **further imaging with triphasic CT or MRI**
- Surveillance imaging** after an interval if still unsure the nature
- Lesions highly suspected to be malignancy undergo **biopsy**

Benign	Malignant
Haemangioma Focal nodular hyperplasia Hepatic adenomas Focal fatty sparing Liver cysts	Hepatocellular carcinoma Metastatic lesions Cholangiocarcinoma



Case 3: Mrs L 38yo ♀ accountant



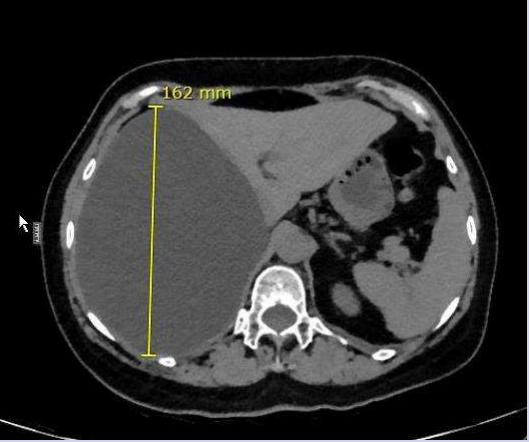
- Upper abdominal discomfort after meals
- Normal liver tests
- USS showed a 5mm hyperechoic lesion in segment 7, consistent with haemangioma

- No history of extra hepatic malignancy
- No chronic liver disease,
- Normal background liver
- Typical features of haemangioma
- <3cm in size

➔ **No further imaging required**



Other benign liver lesions

Focal nodular hyperplasia	Hepatic adenomas	Focal fatty sparing or infiltration	Liver cysts
<p>2nd most common benign lesion ~1% in patients undergoing USS</p> <p>Hyperplastic hepatocytes in response to arterial malformation</p> <p>Excellent prognosis No malignant transformation and often regress. Bleeding rarely reported</p> <ul style="list-style-type: none"> • <u>Asymptomatic small lesions</u> → <u>reassure and discharge</u> • Intervene if symptomatic (rare) 	<p>Usually solitary but phenotype changing to multiple lesions due to increasing metabolic syndrome</p> <p>Malignant transformation: Overall risk 4.2%, usually if >5cm. Haemorrhage if diameter >5cm + exophytic growth</p> <p>More common in women, associated with oestrogen use (30-40x increased incidence with OCP)</p> <ul style="list-style-type: none"> • <u>Stop oestrogen, weight loss</u> • <u>Women with adenoma <5cm monitor with regular imaging, >5cm consider resection</u> • <u>Men → resection regardless of size.</u> • Pregnancy, <u>monitor with USS every 6-12 weeks</u> 	<p>Feature of hepatic steatosis and mimics neoplasia. Usually in the medial segment of left lobe of liver</p> <p>Sometimes picked up as a lesion and requires further CT/MRI to characterise. <u>Reassure and discharge</u></p> 	<p>Solitary or multiple. Can occur in conjunction with other masses in the liver.</p> <p>Majority no follow up required Issues mainly relate to size. Intervene if symptomatic</p> 

Malignant liver lesions

Hepatocellular Carcinoma	Metastatic lesions
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- Usually occurs in underlying liver disease e.g. Cirrhosis, HBV and increasingly MAFLD
- Needs confirmation with triphasic CT/MRI

Early HCC can be treatable:

Treatment options depends on liver synthetic function/size and number of lesions/comorbidities

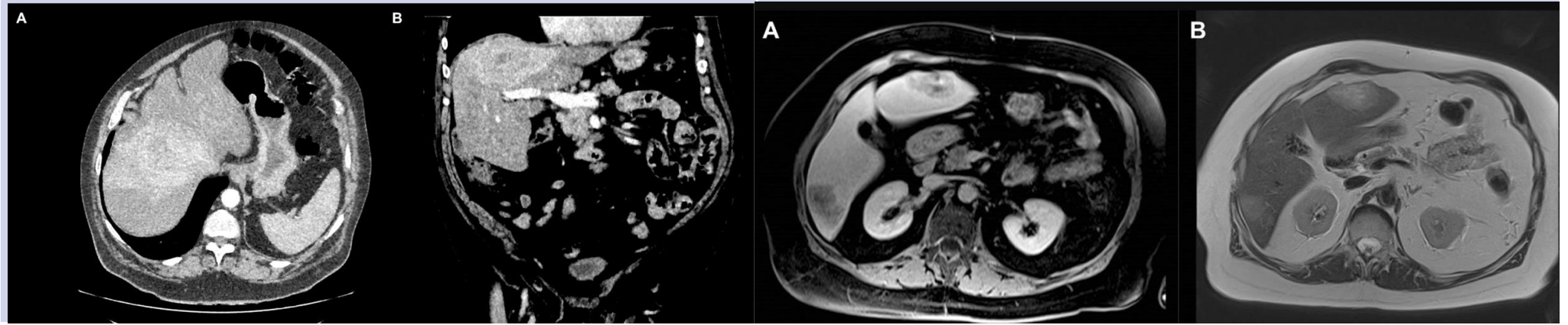
Screening in high risk individuals (who are candidates for transplant or other locoregional therapy) with **6 monthly AFP** and **Liver USS**

- **Cirrhosis**
- **Chronic HBV without cirrhosis but REAL-B score >4**

Multiple lesions distributed throughout liver, unlike HCC

Most commonly:

- Colorectal cancer (Up to 50% of hyperechoic mets)
- Breast cancer
- Endocrine tumours of pancreas
- Renal cell carcinoma
- Thyroid carcinoma
- Melanoma
- Some sarcomas
- Choriocarcinoma



Case 4: Mr P 72yo ♂

- History of chronic back pain on opioids and **chronic constipation**
- Worsening **daily abdominal and thoracic level back** pain 9 months
- Increase **opioid use with pain**
- **10kg weight loss over 2 months**

Background:

- **Obesity** BMI 37 kg/m²
- Previous **10u of alcohol/day** for 15 years
- One pack a day **smoker**

Examination

- Observations normal
- Not jaundiced
- Abdomen soft with no masses

Case 4: Mr P 72yo ♂

- Referred to gastroenterology
- **Initial blood tests**
 - **Lipase 1661**
 - **ALP 159, GGT 222**
 - Bilirubin and ALT normal

Which one of these is FALSE regarding Pancreatic Ductal Adenocarcinoma PDAC?

- A) PDAC has the lowest survival of all cancers
- B) Survival has improved for most cancers over the last 40 years, but not for PDAC
- C) Most are diagnosed at a late stage, not curable with surgery
- D) Ultrasound is very sensitive for early PDAC
- E) Smoking, obesity and pancreatitis are risk factors



➔ Admitted under surgical team for acute pancreatitis

CT imaging demonstrated 2.4cm lesion in the uncinata portion of the pancreas with upstream pancreatic duct dilatation 5mm. Minimal interstitial and peri-pancreatic inflammation.