FK 506 and MMF was given. After taking only 3 doses of 0.1 mg/Kg/day of FK 506, the trough level recorded 28.3 ng/ml at the 2nd postoperative day (POD). On the 4th POD, he moved the bowel 8 times. It was mucoid, blood tinged or hematochezic. Next day, abdominal CT and sigmoidoscopy was done. Ischemic colitis was noted from the hepatic flexure to sigmoid colon on both examinations (Fig.). Peak WBC count was 27,800/㎕ with 92% of neutrophil at the 6th POD. Combined mucormycosis and aspergillosis was diagnosed on pathologic examination of the colonic tissue. Liposomal amphotericin B was given at a dose of 3.5 mg/Kg for 24 days. Oral antifungal agent was not given thereafter. 18 days after the initial sigdmoidoscopic examination, no fungal organism was demonstrated by PAS and GMS staining. However, CMV was positive for nucleus on immunohistochemistry. Gancyclovir was administered intravenously for 2 weeks and then changed to oral Valgancyclovir that was given for another 6 weeks. He was discharged from the hospital 41 days after the LT. And he is in a good general condition without any antifungal or antiviral medication since 6 weeks after the hospital discharge.

Conclusion: Colonic mucormycosis after LT may present as early as 4 days after the operation as a form of ischemic colitis, which shows mucoid and bloody diarrhea. It should be listed as one of the causes of early post-transplant diarrhea, especially in a diabetic recipient who showed poor control of sugar level. Biopsy is essential for a confirmatory diagnosis. A successful outcome would be dependent on the aggressive control of blood sugar level, good general condition (including neutrophilia) and administration of liposomal amphotericin B. It also should be borne in mind that CMV colitis may ensue.

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A Case of Hepatic Angiomyolipoma is Difficult to Exclude Malignancy

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Background: hepatic angiomyolipoma is a rare benign tumor. Since hepatic angiomyolipoma was reported first by Ishak in 1976, only about 200 cases were reported. We report a case of hepatic angiomyolipoma.

Case: A 64-year-old female patient visited to our outpatient department complaing of pitting edema on both legs. She had the history hypertension. Physical examination showed abnormal findings except pitting edema. Abdominal sono showed 3.5 cm size hyperechoic mass in segment II of liver. On admission, laboratory results revealed no abnormal finding including tumor markers. A preoperative MRI showed a 4 cm sized mass has large amount of fat, but it was well enhanced in aterial phase washed out in portal and delayed phase. On the preoperative biopsy of the mass, the tumor has proliferation of atypical spindle cells with high vascularuty and adipose tissue. So it was suspicious fat containing tumor such as angiomyolipoma, hemangioendothelioma, angiosarcoma and liposarcoma but it cannot be exclude possibility of malignancy. Lt. hemihepatectomy was done. Specimen is consisted of left lobe of liver measuring 16x10 cm. On serial section, there is yellowish mass measuring 4x3 cm, which was 2 cm apart from resection margin. The tumor is composed of spindle cells, tortuous vessels and adipose tissue. The tumor cells are positive for Vimentin ,SMA ,HMB45 but negative for hepatocyte antibody, CEA, S-100 and Ki-67 index is about 10~20.

The patient recovered without complication and was discharged on postoperative day 10.

Conclusion: Because it was not reported that hepatic angiomyolipoma has malignant potentials, regular follow up is sufficient to the patient when the tumor was diagnosed with angiomyolipoma. But because it is clinically difficult to exclude possibility of malignancy, resection of tumor is preferred. When hepatic angiomyolipoma was completely resceted, patients can have a good prgnosis with nearly 100% cure rate.