

cinoma. Therefore, even a locally recurrent tumor deserves being aggressively managed to extend survival duration. We report two cases of successful surgery for recurrent IPMC.

#### Materials and Methods

**Case 1:** A 43-year-old male patient underwent curative right trisectionectomy and caudate lobectomy with extrahepatic bile duct resection for a huge poorly-differentiated IPMC (T1) of the left hepatic duct. The regional lymph nodes were not enlarged but the largest one was sampled for biopsy, resulting in no metastasis. Abdominal CT performed postoperative 6 months showed a 3.9 cm-sized mass in the porta hepatis and nodal metastasis was suspected. After further evaluation, the enlarged lymph node was excised and it was proved as metastatic lymph node. Subsequent concomitant chemoradiation therapy was carried out. The patient has not shown any evidence of recurrence for 21 months.

**Case 2:** A 46-year-old female patient underwent radical right hepatectomy with extrahepatic bile duct resection for hilar cholangiocarcinoma. Histopathological examination showed well-differentiated IPMC (T2N0). No postoperative adjuvant treatment was carried out. Abdominal CT performed postoperative 22 months showed newly appeared extrahepatic duct dilatation and smooth short segmental concentric wall thickening in periampullary area of the far distal CBD. Consecutive endoscopic examination demonstrated mucin expulsion from the ampulla and recurrent tumor was suspected. Pylorus-preserving pancreaticoduodenectomy was performed and pathologic results were IPMC (T1N0) in the background of papillomatosis. The patient has not shown any evidence of recurrence for 12 months.

**Conclusions:** Because IPMC tends to show a gentle biological behavior and a favorable prognosis, an aggressive surgery could be treatment of choice for locally recurrent tumor in selected cases as well as for initially diagnosed IPMC.

### Successful Treatment of an Iatrogenic Ruptured Right Hepatic Artery Pseudoaneurysm with a Stent Graft

Division of Hepato-biliary Surgery and Transplantation,  
Department of Surgery, Pusan National University Yangsan  
Hospital, Korea

**Je-Ho Ryu, Kwang-Ho Yang, Ki-Myung  
Moon, Chong-Woo Chu**

A 62-year-old man presented with an iatrogenic ruptured right hepatic artery pseudoaneurysm after a laparoscopic cholecystectomy. He underwent a laparoscopic cholecystectomy due to chronic cholecystitis with gallbladder stones in a local clinic. Approximately 12 days after the cholecystectomy in a local clinic, he was admitted to our hospital emergency center with a "crampy" epigastric pain and hypotension. Imaging studies demonstrated a pseudoaneurysm of right hepatic artery, with hemoperitoneum at GB fossa, subcholecystic space, perihepatic space and perisplenic space. There was no evidence of active bleeding on imaging studies. Selective celiac arteriography showed an occlusion of the right hepatic artery with a large pseudoaneurysm arising from an occluded segment. This was treated with a 4-x 26-mm stent graft (Jostent; Abbott Vascular, Temecula, Calif) with good result. The completion arteriogram showed wide patency of stent graft with total exclusion of pseudoaneurysm. However, 3 days after stent graft insertion, he complained with extremely cramping right upper quadrant pain. Follow-up imaging studies demonstrated an interval increase in size of sac of pseudoaneurysm. Selective celiac angiography showed contrast extravasation from proximal portion of the stent graft. So, This was treated with a 4-x 19-mm stent graft (Jostent; Abbott Vascular, Temecula, Calif), overlapped with the proximal portion of the previous stent graft. Follow-up dynamic CT scans up to 40 days after procedures showed no evidence of residual pseudoaneurysm and wide patency of the stent graft. The patient continues to do well clinically.