aged with surgical options due to the tumor extension and the diseased liver. Over the last eight months, she has developed recurrent cholangitis and needed multiple percutaneous transhepatic catheters placement for drainage of mucin from her biliary tree. We have never been able to diagnose carcinoma. She has been listed up for OLT with a MELD exception score of 25 and matched MELD of 19 at March 2, 2010. On June 23, 2010, she underwent a successful OLT. The final pathologic report of the explant showed well-differentiated mucinous carcinoma arising from intraductal papillary neoplasm. Patient had one episode of acute cellular rejection which was managed by increasing a dose of immunosuppressant. The patient has showed no evidence of recurrence until after 9 months.

Conclusion: Even though many reports showed a good prognosis for mucin-producing biliary tumor after aggressive surgical resection, OLT could be a good option for patients with a mucin-producing biliary tumor arising from PSC.

4

Extra-Gastrointestinal Stromal Tumor of the Pancreas: Report of a Case

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Research Purpose: Gastrointestinal tumors are mesenchymal tumors that arise from the gastrointestinal tract. These tumors are mainly stomach, jejuneum and ileum. In rare cases, these tumors are found in the pancreas. EGISTs of the pancreas are exceedingly rare and only eleven cases have been reported in the literature, so clinicopathologic features are not fully elucidated. Herein, We report a case of a pancreatic extragastrointestinal stromal tumor in a 64-year-old female patient together with a review of the literature.

Materials and Methods: We report a case of GIST in the pancreatic head. A 64-year-old women was referred to us for treatment of an abdominal mass detected by ultrasonographic examination. Under a preoperative diagnosis of a duodenal GIST, we performed a pylorus preserving pancreatoduodenectomy for this lesion.

Results: The laboratory examination was within normal range. On pathologic gross examination, the tumor measured 7 cm at its greatest dimension and involved the pancreatic head. The cut surface was rubbery and white. It was surrounded by a thin pseudocapsule and well demarcated, but shown to infiltrate the duodenal wall. Histopathological examination of specimen showed a cellular lesion with compressed pancreatic tissue at peripheral. Mitotic figures were 5/50 high power fieled. Immunohistochemically, neoplastic cells were positive for antibodies against C-KIT (CD117); whereas, smooth-muscle actin, reactions with antibodies against S-100, CD34 and desmin were negative. Based on the above findings, the tumor was finally diagnosed as malignant GISTs originating from the pancreas.

Conclusion: Although rare, EGISTs should to considered in the differential diagnosis of the more common solid neoplasms of the pancreas.

5

Complicated Cholecystitis Following Diaphragmatic Rupture

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A 44-year-old female was referred to our hospital in January 2011 for further evaluation for pleuritic chest pain. She had medical history of traumatic SAH and right side rib fracture caused by car accident in 2006 and she suffered intermittent right chest pain, febrile sensation, and dyspnea since 2010. Ten days prior to admission, pleuritic pain, dyspnea were more aggravated and she visited local medical center. On examination, chest computed tomography showed right side diaphragmatic rupture with herniated liver: left hemiliver and a part of anterior section which were flipped 90 degree ventrally. Futhermore, there was impacted gallstone, gallbladder wall thickening, and pericholecystic abscesses. On admission, she complained of dyspnea, pleuritic pain relieved by left lateral decubitus position. She was diagnosed with blunt right diaphragmatic rupture with hepatic hernia and compli-

cated cholecystitis.Initially, we worried about possibility of optimal positioning of liver because volumetric calculation of the intrathoracic portion of liver ,calculated by computed tomography imaging, were 802 cm^3 which was three times of intraabdominal liver volume. Therefore, we contemplated closure of diaphragm using artificial patch, which was weak to contaminated field, or colonic mobilization through additional abdominal incision. However, We could perform cholecystectomy, reduction of liver, and primary repair of diaphragm via thoracic approach without additional abdominal incision or use of artificial patch with good result.

6

Synchronous Double Cancer with Adenocarcinoma of Distal Common Bile Duct and Intraductal Papillary Mucinous Carcinoma of the Pancreatic Head

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Introduction: Synchronous or metachronous malignancies have been identified in 10-52% of patients with intraductal papillary mucinous neoplasms of the pancreas. The gastrointestinal tract is most commonly involved in secondary malignancies, with benign colon polyps and colon cancer commonly seen in western countries and gastric cancer commonly seen in Asian countries. Other extrapancreatic malignancies associated with papillary mucinous neoplasms include benign and malignant esophageal neoplasms, gastrointestinal stromal tumors, carcinoid tumors, hepatobiliary cancers, breast cancers, prostate cancers, and lung cancers. But a case of intraductal papillary mucinous neoplasm with synchronous distal common bile duct cancer reported very rarely.

Case Presentation: A 73-year old man presented with abdominal pain and anorexia. Clinical examination revealed tenderness and rebound tenderness in the right upper quadrant of the abdomen. Blood tests demonstrated elevated transaminase, amylase, lipase, and bilirubin levels. The level of tumor markers was within the normal limits. Abdominal computed tomography and magnetic resonance imaging showed about a 1.8 cm ill-defined enhancing lesion in the distal common bile duct and 2 cm-sized mutiloculated cystic lesion in the uncinate process of the pancreas. The initial impression was intraductal papillary mucinous carcinoma in the pancreas, invaded to a distal common bile duct. The patient underwent pancreaticoduodenectomy. Gross pathologic examination revealed a 1×1 cm-sized fungating mass in the distal common bile duct and mucinous cystic mass with dilated pancreatic duct in the pancreatic head. The histopathology helped make the diagnosis of synchronous double cancer with adenocarcinoma of distal common bile duct and intraductal papillary mucinous neoplasm with an associated invasive carcinoma of the pancreatic head. The patient was discharged on the 12th postoperative day with uneventful recovery. He had received gemcitabine-based chemotherapy 3 times at 3-week intervals. There was no evidence of recurrence in the 1 month after surgery.

Discussion: Synchronous double cancers are defined as those cases that display primary malignant tumors of different histologic origins in one person. As the diagnostic methods have developed and the average life span has been extended, the diagnosis of multiple primary tumor has also increased. In our case, the initial radiologic diagnosis was intraductal papillary mucinous carcinoma in the pancreas, invaded to a distal common bile duct. However, the final pathologic diagnosis was synchronous double cancer with adenocarcinoma of distal common bile duct and intraductal papillary mucinous neoplasm with an associated invasive carcinoma of the pancreatic head.

7

Successful Surgical Treatment for Recurrent Intraductal Papillary Mucinous Cholangiocarcinoma: Two Cases

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Research Purpose: Intraductal papillary mucinous cholangiocarcinoma (IPMC) is known to have a favorable prognosis compared to a flat-type cholangiocar-