This case highlights a peculiar case of biliary septic shock caused by infected liver biliary hamartomas.

adenomas, and Caroli’s disease for this imaging appearance includes metastasis, simple liver cysts, liver cancer, biliary ductal plate malformations involving the small interlobular bile ducts. The cysts are typically uniform roughly 0.6-2.8% of the general population. Multiple biliary hamartomas are thought to arise from Caroli’s disease. Albert unclear, MBH may be a risk factor for cholangiocarcinoma.

A Starrv Sky Liver: Klebsiella Pneumoniae Septic Shock Caused by Infected Multiple Biliary Hamartomas

Zachary Neubert, DO, MS1, Nader Mirhosseni, MD2, Robert D. Lawson, MD1.

INTRODUCTION: Biliary hamartomas or von Meyenburg complexes are an exceedingly rare benign cystic disease of the liver. They are diagnosed radiographically due to a distinct appearance. The patient developed cirrhosis and subsequent decompensation of hepatic encephalopathy and ascites approximately twenty months after his initial diagnosis of overlap syndrome. He is currently undergoing transplant evaluation.

DISCUSSION: This is a rare case of overlap syndrome of PBC and PSC. At present, there are no consensus guidelines on the diagnosis and management of this syndrome. Given the rarity of this condition, there is currently no available data on long term outcomes in patients with overlap of PBC and PSC.

A Rare Presentation of Sarcoidosis Diagnosed as Pancreatic Sarcoidosis

Kushal Shukla, MD, David Rahni, MD, FACG.

INTRODUCTION: Sarcoidosis is a non-caseating granulomatous multisystem inflammatory disease of unknown cause affecting many worldwide. In 95% cases, pulmonary and mediastinal lymph nodes are involved. Pancreaticobiliary involvement is exceedingly rare 1-6%. Clinically recognizable gastrointestinal sarcoidosis occurs in 0.1 to 0.9% of patients. Pancreatic sarcoid can mimic clinical and radiological findings associated with tuberculosis and malignancy.

CASE DESCRIPTION/METHODS: Here, we present a 50-year-old male patient male with past medical history of diabetes, hypertension, hyperlipidemia and treated syphilis presented to ED with diarhea, abdominal pain and shortness of breath. Physical exam was significant for hypotension with O2 sat 92% on room air and ascites with shifting dullness. Labs were unremarkable including normal lpaue dliver function tests. CTA of chest showed no pulmonary embolism but had enlarged peripancreatic, perieliac, mediastinal lymph nodes with nodular liver. MRCP showed patent pancreatic and biliary duct with right sided compressive atelectasis and nodular contour liver without focal hepatic lesions. No focal masses or inflammatory changes seen within pancreas but showed small focal lesions posterior to pancreas at the level of celiac axis measuring 11 mm and 7 mm read as nonpecific pancreatic lymphadenopathy. EUS directed biopsy of periapapillary lymph node was significant for non-caseating granuloma with negative Acid fast stain and nonmalignant cells. Patient’s aciexs and oxygenation improved after dexamethasone treatment.

DISCUSSION: On literature review patients with pancreatic sarcoidosis have abdominal pain 66%, weight loss 49%, obstructive jaundice 29%, emesis 26%, pruritus 12%, fever 8%, diarrhea 4%, abdominal distention 4% and ascites 4%. Lymphadenopathy is the most common findings on imaging with most common hilar and paratracheal 90% to very uncommon intraduodenal lymphadenopathy 30%. Tissue biopsy of the pancreatic lymph node is required to differentiate pancreatic sarcoidosis from other inflammatory and malignant disorders of the pancreas as laboratory findings are not specific for diagnosis. The prognosis of mild pancreatic sarcoidosis is good and in severe form its variable. Corticosteroids is the drug of choice and remission rate in severe form after stopping is 100%.

Non-steroidal drugs have been used for treatment of some refractory life-threatening forms of sarcoidosis such as methotrexate, hydroxychloroquine and azathioprine.

Figure 1. MRCP Multiple Biliary Hamartomas.

Figure 2. Posterior pancreatic lymph nodes.