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Rim ^{18}F -FDG uptake of hepatic cavernous hemangioma on PET/CT: a case report

Yongan Hu, Yaxin Guo, Qifeng Huang

Abstract**BACKGROUND**

Peripheral FDG accumulation in a hepatic hemangioma presenting in a patient with prolonged fever is rare. Therefore, clinicians should pay close attention to patients with hepatic mass.

CASE SUMMARY

A 54-year-old woman with a 4-week history of daily fevers was admitted to our hospital. A whole body ^{18}F -FDG PET/CT was performed to elucidate the source of the fever. However, whole body ^{18}F -FDG PET/CT raised the suspicion of a malignant lesion because of peripheral FDG accumulation (SUVmax 3.5 g/mL) higher than that of the normal liver parenchyma (SUVmax 1.6 g/mL) surrounding a hypoactive area, and no other abnormalities were showed. Subsequently, the patient underwent liver mass resection. Histopathology showed a hepatic cavernous hemangioma with fatty infiltration around the lesion. The fever disappeared four days after surgery and the patient did not present any complications during follow-up.

CONCLUSION

Fatty infiltration in the peripheral parts of hepatic cavernous hemangioma may lead to subacute inflammation which further activate the Kupffer cells. This may cause prolonged fever and peripheral rim FDG accumulation on PET/CT.

INTRODUCTION

Cavernous hemangioma⁸ is the most common benign hepatic tumor, with a prevalence of 0.4 to 20% in the general population and is believed to arise from vascular malformations although some studies¹ have suggested it might originate from hepatic areas of focal necrosis and regeneration. It can occur in any age group, but is most prevalent in middle-aged women (the female to male ratio is 5:1). Hepatic cavernous hemangioma usually presents as a solitary lesion, but 2–30% of patients may present with multiple lesions. Most of the hepatic cavernous hemangiomas are small, asymptomatic, and detected incidentally, but large ones can occasionally cause symptoms or complications such as fever, jaundice, nausea, vomiting, rupture. Giant lesions can stretch the Glissonean capsule causing pain that may influence the patient's quality of life.

The typical characteristics of hepatic cavernous hemangiomas on CT or MRI are progressive peripheral nodal enhancement at dynamic imaging and delayed centripetal fill-in, making their diagnosis straightforward.⁴ Stable appearances on serial imaging and the absence of vascular flow on Doppler ultrasound are also helpful diagnostic cues for hepatic cavernous hemangiomas. However, atypical hemangiomas can be confused with malignant lesions such as intrahepatic cholangiocarcinoma, hepatocellular carcinoma, mixed hepatocellular-cholangiocarcinoma, and angiosarcoma. FDG uptake of hepatic cavernous hemangiomas is usually low. Thus, ¹⁸F-FDG PET/CT is suggested to distinguish benign lesions from malignant lesions when CT and MRI suspect cavernous hepatic hemangioma but cannot exclude malignancy because of its larger size and degeneration. Treatment depends on the size of the tumor and the symptoms. Asymptomatic patients and patients with hepatic lesion size ≤ 5 cm or with growth rate ≤ 3 mm per year do not require treatment. Otherwise, therapy most often is surgical resection of the lesion, after which recurrence or growth of residual small lesions is rare. A few cases were reported of orthotopic liver transplantation for large or diffuse

bilateral lesions. Transcatheter arterial embolization and radiation therapy are alternatives in patients unfit for surgery.

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CASE PRESENTATION

Chief complaints

A 54-year-old woman with a 4-week history of daily fevers was admitted to our hospital.

History of present illness

The patient had daily fevers (up to 39.2°C) for 4 wk of unknown origin.

History of past illness

She was in good health and her past medical history was unremarkable.

Personal and family history

The patient denied any family history of malignancy.

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Physical examination

Body temperature was 38.4 °C, blood pressure was 117/82 mmHg, heart rate was 85 beats/min, respiratory rate was 20 breaths/min and her oxygen saturation was 98%.

Laboratory examinations

Blood tests indicated an elevation in neutrophils (81.5%), C-reactive protein (118.2 mg/L), alkaline phosphatase (147.0 IU/L), and γ-glutamyl transpeptidase (59.9 U/L).

Imaging examinations

Abdominal ultrasound was performed showed a 10.0×7.0 cm heterogeneous hyperechoic mass in the left liver lobe. On dynamic contrast-enhanced CT, peripheral nodular enhancement in the arterial phase and gradual fill-in in the delayed phase were seen in the mass, which are findings typical for cavernous hemangioma. A whole body

18F-FDG PET/CT was performed to elucidate the source of the fever. However, whole body 18F-FDG PET/CT raised the suspicion of a malignant lesion because of peripheral FDG accumulation (SUVmax 3.5 g/mL) higher than that of the normal liver parenchyma (SUVmax 1.6 g/mL) surrounding a hypoactive area ,and no other abnormalities were showed.

FINAL DIAGNOSIS

Hepatic cavernous hemangioma.

TREATMENT

Preoperative needle biopsy was not undertaken given the risk of bleeding because the tumor was highly vascular. Subsequently, the patient underwent liver mass resection. At gross examination, the tumor was a dark red mass of 10 cm in diameter. Histopathology showed a hepatic cavernous hemangioma with fatty infiltration around the lesion.

OUTCOME AND FOLLOW-UP

The fever disappeared four days after surgery and the patient did not present any complications during follow-up.

DISCUSSION

While it has been suggested that low uptake of FDG could be useful to distinguish between benign hemangioma and malignant liver lesions, in the case presented here, a pathologically confirmed hepatic cavernous hemangioma showed a SUVmax (maximum standardized uptake value) in the margin of the lesion which was higher than that of the normal liver parenchyma. We suspect that this may result from the fatty infiltration. Uptake of FDG in focal fatty infiltration of the liver has been reported and has been attributed to activation of Kupffer cells. A mouse model provided evidence that lipid accumulation in the liver leads to subacute hepatic 'inflammation' through

NF-kappa activation and downstream cytokine production and that Kupffer cells may activated. However, as the latter reference mentions, the ¹ approximately twofold activation of hepatic NF-κB is in contrast to the much greater, many-fold activation that typifies acute inflammatory reactions. Therefore, it remains speculative whether the fever in the patient described here could have been related to the uptake of FDG in the hemangioma. Fever has seldom been reported in hepatic hemangioma. One study suggested that necrotic changes within the hemangioma may cause fever. However, necrotic changes have not been seen in our patient. Moreover, no histologic evidence was found of infection of the hemangioma, which conceivably would constitute a differential explanation of the fever and of the FDG accumulation. Moreover, the peripheral nature of the FDG accumulation would be unexpected in case of infection and it seems unlikely that any inflammatory infiltrate would have cleared entirely. Still this we cannot formally rule out this possibility.

CONCLUSION

Fatty infiltration in the peripheral parts of hepatic cavernous hemangioma may lead to subacute inflammation which further activate the Kupffer cells. This may cause prolonged fever and peripheral rim FDG accumulation. We observed peripheral FDG accumulation in a hepatic hemangioma presenting in a patient with prolonged fever. This probably relates to fatty infiltration at the border of the hemangioma and resulting Kupffer cell activation. Since the fever disappeared after resection of the hemangioma, this might suggest that it may have been caused by inflammation induced by the hemangioma.

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