Commentary

MBHs are rare benign liver lesions, also known as von Meyenburg complexes, and were first described in the early 20th century. They consist of multiple small interlobular biliary cystic lesions or hamartomas that are not connected to the main biliary tree. MBHs are the result of biliary ductal plate malformations during embryonic development. MBHs are usually asymptomatic and are found incidentally. It is key to differentiate MBHs from metastases, simple liver cysts, and Caroli's disease.

MBHs are easily detectable on cross-sectional imaging, and a liver biopsy is usually not necessary. MRCP with contrast material reveals multiple small (<15-mm) irregular cystic liver lesions without attenuation or enhancement, and the extrahepatic and intrahepatic biliary trees are normal. By contrast, liver metastatic lesions and Caroli's disease show contrast enhancement. As seen in the case described here, MBHs can become infected, which can lead to cholangitis and life-threatening septic shock, as seen in this case.

Fewer than 15 MBH cases of cholangitis have been reported in the literature. The most common reported microorganisms *are Escherichia coli, Enterococcus faecium, Enterobacter cloacae*, and *Klebsiella pneumoniae*. Over 90% of reported cases of MBHs with cholangitis had a single cholangitis episode and responded to intravenous antibiotics. Notably, Panda et al reported a case of MBH that required liver transplantation for the treatment of recurrent cholangitis. Finally, MBHs are rare biliary duct congenital abnormalities that can be complicated by cholangitis, but they usually respond to antibiotics, and endoscopic or surgical interventions are generally not necessary in most instances.

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Acute pancreatitis due to intragastric balloon hyperinflation (with video)

We present the case of a 53-year-old woman who underwent intragastric balloon (IGB) placement for obesity (body mass index [BMI], 30.2 kg/m^2) after medical therapy had failed. The IGB was filled with 700 mL saline solution. On postoperative day 42, she experienced severe abdominal pain, without nausea or fever. The patient had bulging of the abdominal wall and presented with diffuse pain and tenderness (**A**).

An abdominal radiograph showed hyperinflation if the IGB (**B**). Laboratory tests showed elevated C-reactive protein (32 mg/L), amylase (550 U/L), and lipase (1890 U/L), and normal white blood count. CT showed distension of the IGB (1200 mL), with an air-fluid level, compressing the body of the pancreas with upstream pancreatic duct dilatation. Additionally, a tear in the rectus abdominis was seen (**C**) (Video 1, available online at www.giejournal.org).

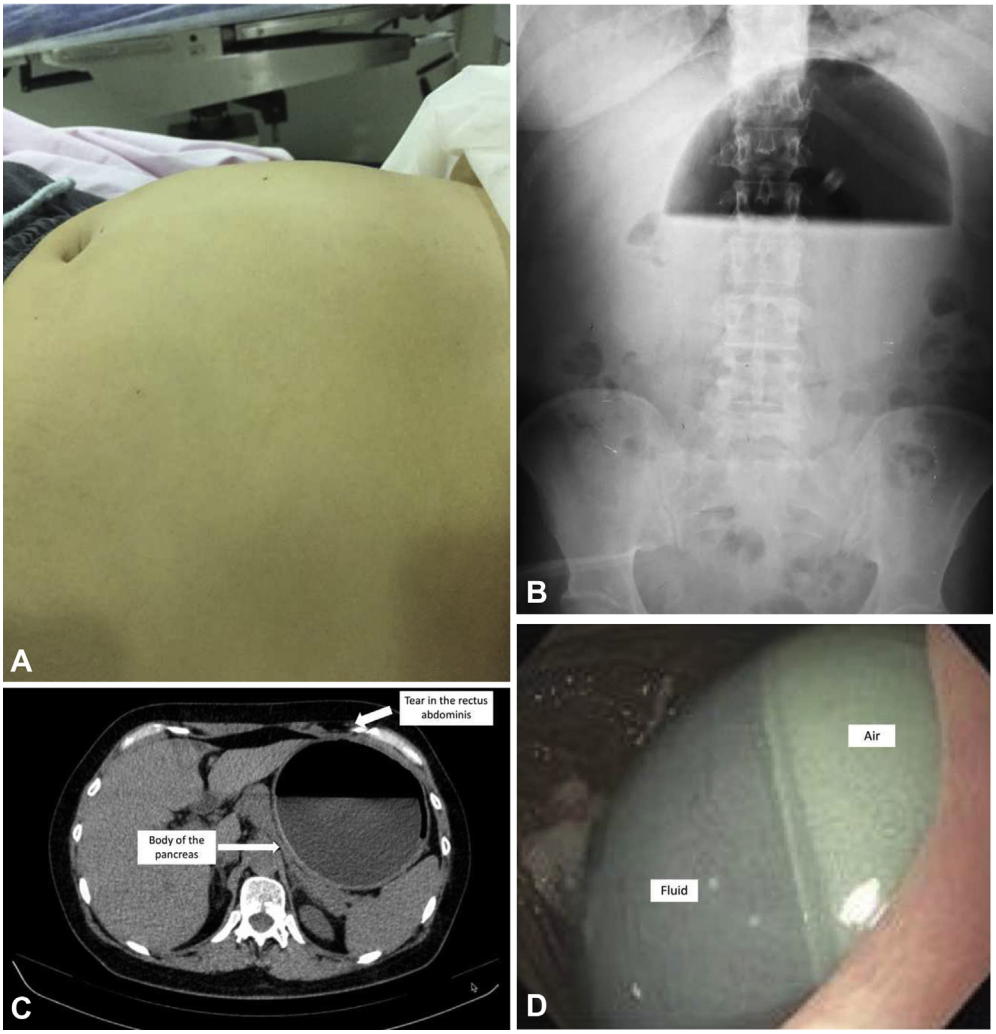
EGD confirmed hyperinflation, and IGB removal was performed (**D**). The patient had improvement of her symptoms and was discharged on the second day after removal of the IGB. During follow-up, US of the abdomen showed no stones or sludge in the gallbladder and no dilatation of the pancreatic duct. Additionally, laboratory test results had normalized.

In summary, hyperinflation of an IGB can occur, and early diagnosis with IGB removal is essential to avoid severe adverse events.

This video can be viewed directly from the GIE website or by using the QR code and your mobile device. Download a free QR code scanner by searching "QR Scanner" in your mobile device's app store.

DISCLOSURE

Dr Thompson is a consultant for Boston Scientific, Olympus, Apollo Endosurgery, Fractyl, and USGI Medical. The other authors disclosed no financial relationships.



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Commentary

IGB therapy has come and gone and has now come back again. Many surgeons and gastroenterologists in the United States are now once again placing IGBs as a means of nonsurgically promoting weight loss in their patients. This case illustrates multiple adverse events (eg, rectus abdominus tear, muscle pancreatitis, abdominal distension) resulting from overinflation of an IGB.

This patient was treated by removal of the offending overinflated IGB, which seems reasonable. Another option, if the device would allow it, is partial deflation to reduce the mechanical pressure on nearby organs, although that was not done in this patient. Despite the benefits of these devices, they do have drawbacks, and every center that places them has seen

some therapeutic misadventures. The ideal endoscopic treatment for obesity has yet to be developed, but balloons represent an intermediate step that allows patients to achieve some meaningful success.

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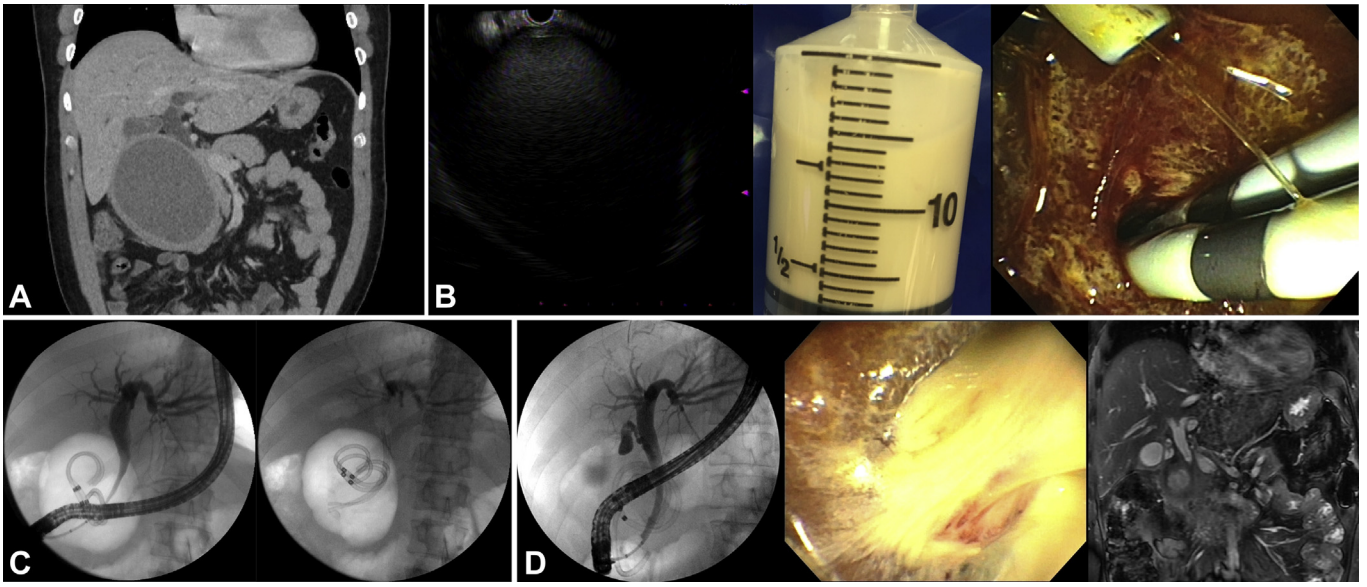
Spontaneous lymphocele presenting with obstructive jaundice



A 40-year-old man with known retroperitoneal lymphocele presented with right upper quadrant pain and jaundice. He did not describe abuse of tobacco or alcohol, pancreatitis, or a history of trauma or abdominal surgery. He had a tender palpable mass in the right upper quadrant and laboratory results significant for obstructive cholestasis. CT showed a lymphocele measuring 9.4 × 8.6 cm (previously 4.4 × 4 cm), with biliary ductal dilatation (**A**). He underwent EUS cystduodenostomy (cyst fluid consistent with lymphocele) by the use of two 10F × 1-cm double-pigtail stents (**B**); the result of cytologic analysis was negative for malignancy. ERCP showed a 25-mm stenosis of the distal common bile duct, with upstream dilatation to 16 mm, treated with stent placement (10F × 7 cm, 7F × 7 cm) (**C**), which resolved his jaundice. All stents were removed 2 months later, and a cholangiogram showed stricture resolution, with the fistula draining lymphatic fluid (**D**). Follow-up magnetic resonance imaging 4 months later showed significant sustained improvement of the lymphocele (**D**).

Lymphoceles usually result from trauma, surgery, or malignancy. Spontaneous lymphoceles are rare. Although they are mostly asymptomatic, symptoms can include abdominal discomfort and constipation. Treatment involves surgical or percutaneous drainage, with endoscopic drainage (transgastric) reported once previously. We believe this is the first reported case of obstructive jaundice from a lymphocele and treatment by transduodenal drainage. The permanent duodenal fistula enabled continuous enteric drainage, preventing symptom recurrence.