Granular cell tumour of the common bile duct

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Summary: Granular cell tumours are a rare cause of benign biliary stricture. A case is reported which is unusual in that the diagnosis was made before the onset of jaundice. We emphasize the importance of accurate histology of biliary strictures, to eliminate confusion between those of benign and malignant nature and to ensure that the appropriate management is undertaken. Immunohistochemical evidence for the neural origin of this rare tumour is presented.

Introduction

Granular cell tumours (GCT) are uncommon benign lesions whose histogenesis has remained obscure since their description by Abrikosoff in 1926. Their occurrence in the extrahepatic biliary tree is rare and of the 33 cases so far described, only 3 have been reported in the British literature (Savage & Devitt, 1977; Dewar et al., 1981; Barber, 1984). A granular cell tumour of the common bile duct is described which is unusual in that the diagnosis was made before the onset of jaundice.

Case report

A 38 year old Caucasian woman presented with a one year history of recurrent attacks of colicky, right hypochondriac pain each lasting several hours. There was no history of jaundice and examination was unremarkable.

An oral cholecystogram failed to opacify the gall bladder but ultrasound examination of the gall bladder was normal. Liver function tests performed shortly after an attack of pain showed: alkaline phosphatase 345 IU/l (normal 30–110 IU/l), aspartate transaminase 99 IU/l (normal 5–40 IU/l) and bilirubin 15 μmol/l (normal 5–17 μmol/l). In the absence of gallstones and with abnormal liver function tests bile duct obstruction was suspected. Endoscopic retrograde cholangiopancreatography (ERCP) showed a tight stricture in the mid-portion of the bile duct, absent filling of the cystic duct and dilatation of the biliary tree above the stricture (Figure 1).

A malignant bile duct stricture was suspected and at laparotomy a 1 cm firm nodule was found in the

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common bile duct at its junction with the cystic and common hepatic ducts. The common hepatic duct was dilated and the gall bladder collapsed. The nodule was resected with a cuff of normal bile duct, cystic duct and gall bladder and a Roux-en-Y hepato-jejunostomy performed. The patient made an uncomplicated recovery and remains well 2 years later.

Pathology

A firm nodule measuring 1 cm in diameter with a yellow-white cut surface was noted within the wall of the common bile duct almost occluding its lumen and completely obstructing the cystic duct. The gall bladder was normal and did not contain stones. Histologically, the lesion did not appear encapsulated and was composed of clumps of large cells with distinct cell boundaries, small dark round nuclei and eosinophilic granular cytoplasm. These are the features of a granular cell tumour.

In some areas the tumour cells were closely associated with nerve bundles of an unusually large size for the biliary tree. The tumour cells showed staining for S-100 protein, neurone-specific enolase (NSE) (Figure 2) and PGP 9.5. S-100 protein is a marker for Schwann cells, Langerhans cells and cartilage whilst NSE and PGP 9.5 are markers for neural and neuroendocrine tissue. Staining of the tumour cells with these markers provides evidence for the neural origin of GCT.

Discussion

Benign tumours of the extrahepatic biliary tree are uncommon and are usually epithelial (papillomas and adenomas) or predominantly epithelial (adenomyomas and polyps). Granular cell tumours at this site are rare. There have been 33 cases reported including 16 in the common bile duct (Figure 3). A review of these cases shows that GCT of the extrahepatic biliary tree occurs almost exclusively in women (94%) and usually presents in the third to fifth decades. It appears to be more common in negroes as is true of GCT found at other sites (Lack et al., 1980). GCT is occasionally multiple: one patient had multiple tumours in the biliary tree (Aisner et al., 1982) and four had tumours elsewhere (Assor, 1979; Manstein et al., 1981; Livolsi et al., 1973).

The clinical features of granular cell tumour resemble those of both malignant bile duct strictures and gallstones. The benign nature of this tumour may be suspected at operation but confirmation of the diagnosis depends on histological examination of the resected specimen. Except for two tumours found at post-mortem (Coggins, 1952; Whitmore et al., 1969) all previously reported lesions have been successfully treated surgically.

GCT is much more common at sites outside the biliary tree and has been described in most parts of the body. The commonest sites are the skin, subcutaneous tissues, oral cavity and tongue (Lack et al., 1980). At certain sites such as the biliary tract, bronchus (Garancis et al., 1970), vocal cord or oesophagus (Mauro & Jacques, 1981) GCT can produce significant symptoms and may be mistaken for a malignant lesion.
The histogenesis of GCT is unclear, a neural origin being the most widely accepted view at present. These tumours are often closely associated with nerves and occasionally wholly confined within a nerve (Bangle, 1953). GCT cells contain granules resembling the secretory granules characteristic of neural cells and show immunohistochemical staining for the Schwann cell marker S-100 protein (Dhillon & Rode, 1983) and the neural markers PGP 9.5 andNSE (Rode et al., 1982, 1985). A Schwann cell origin has been proposed (Fischer & Wechsler, 1962) but more recently Rode et al. (1982) suggested that this tumour arises from an undifferentiated precursor cell which has the capacity to differentiate into either Schwann or GCT cells.

Granular cell tumour is a rare, benign lesion which may cause bile duct obstruction and should be considered in the differential diagnosis of biliary pain with or without jaundice. Accurate histology of biliary strictures is important to eliminate confusion between those of benign and malignant nature and to ensure that the appropriate management is undertaken.

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References


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