Coffee Bean Sign With a Twist

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Question: An 84-year-old woman with a stable hepatic cyst of 7 years’ duration presented from her nursing home with abdominal distention and pain, decreased oral intake, and intermittent nonbloody nonbilious emesis for 1 week. She had been previously healthy and without history of abdominal surgery. There was no report of fever, diarrhea, constipation, hematochezia, or melena.

On examination, the patient was hemodynamically stable. Her abdomen was soft, distended, and diffusely tender to palpation without rigidity, rebound, or guarding. Laboratory tests were remarkable only for acute kidney injury with a creatinine of 4.31 mg/dL. An abdominal radiograph (Figure A) suggested dilatation of a large bowel loop with an air–fluid level concerning for colonic volvulus, most likely sigmoid. A computed tomography scan of the abdomen and pelvis was ordered and gastroenterology was emergently consulted.

What is the diagnosis?

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Conflicts of interest
The authors disclose no conflicts.

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Subsequent computed tomography scan of the abdomen and pelvis showed an enlarged liver cyst causing gastric outlet obstruction (Figure B). A nasogastric tube was placed, and the patient was referred for endoscopic cyst drainage. Unfortunately, an incidental large pericardial effusion prevented cardiology clearance for endoscopy. She instead underwent image-guided drainage of the cyst by interventional radiology. Her symptoms improved, and she was discharged with an external drain. Within 2 weeks of her drain being removed, her symptoms recurred. She was found to have reaccumulation of fluid, and the drain was replaced by interventional radiology to remain indefinitely.

To our knowledge, compression by a hepatic cyst causing gastric outlet obstruction has not been previously reported in the literature. This case emphasizes the lack of specificity of abdominal radiographs, particularly the coffee-bean sign, and the importance of computed tomography scanning when evaluating for sigmoid volvulus.1 Gastric outlet obstruction and sigmoid volvulus can have similar presentations with abdominal distention, pain, nausea, and vomiting. A broad differential should be maintained while awaiting computed tomography results. Hepatic cysts have a spectrum of etiologies and manifestations. Simple hepatic cysts owing to congenital anomalies are often asymptomatic and incidentally found on imaging.2 Enlarging cysts cause a range of symptoms including jaundice from biliary system compression, portal vein occlusion, inferior vena cava compression, arrhythmia, or gastrointestinal obstruction.3 Although this patient could not be treated endoscopically owing to cardiac concerns, the rapid reaccumulation of fluid after external drain removal supports the role of endoscopic drainage of large hepatic cysts in appropriately selected patients.

References