

CASE REPORT

The Role of Endoscopic Ultrasound in Primary Pancreatic Lymphoma Presented with Acute Pancreatitis: A Case Report

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ABSTRACT

Context Primary pancreatic lymphoma (PPL) is rare but manageable malignant tumor of the pancreas which may be confused with pancreatic adenocarcinoma. **Case report** We report a 38 year-old smoker man with IVDA and history of B (inactive carrier), C (Ia genotype) hepatitis and negative for HIV admitted to our hospital because of nausea, vomiting, epigastric and RUQ pain as a result of long period of alcohol consumption. Due to high amount of amylase (480 U/L) and lipase (326 U/L) Pancreatitis was diagnosed. Four days after admission CT was done that showed enhancement a large tumor of the head of the pancreas. Endoscopic ultrasound (EU) revealed diffusely enlarged of pancreas. There was a mixed echoic mass lesion 37-50 mm at the head of pancreas (R/O walled off necrosis) with adhesion to portal vein and SMV. On the other hand the CBD was 9 mm. Abdominal MRI and MRCP for patient was done. The intra-hepatic bile ducts, main hepatic ducts, CHD and CBD were mildly dilated and displaced to the right side by a large lobulated mass (160×112×130 mm) of pancreatic head with low signal intensity on T1W images and high intensity on T2W images. We did EUS-FNA and there was a mixed echoic lesion (38-40 mm) adhered to head of pancreas with invasion to portal vein, SMA and SMV. The diagnosis of pancreatic lymphoma was established by immunohistochemical study and the assessment of the neoplastic cells revealed B cell lymphoma phenotypes. **Conclusion** Herein we present an interesting 38 year- old man with pancreas head tumor. Primary pancreatic lymphoma is almost never suspected clinically. It is usually diagnosed by imaging and histological methods.

INTRODUCTION

Most primary pancreatic lymphomas (PPL) are non-Hodgkin's lymphomas (NHL). More than 25 percent of NHL originates from extra-lymphatic organs, about 30 percent of which may involve the pancreas [1]. The gastrointestinal tract, especially the stomach and the small bowel, is the most commonly involved extranodal site, accounting for about half cases [2]. PPL is a rare extra-lymphatic NHL of the B cell type that comprising less than less than 1 to 2% of all extra-lymphatic lymphomas, and 0. 5% of pancreatic tumors [3, 4]. Symptoms, imaging and tumor markers can mimic pancreatic adenocarcinoma thus PPL can be difficult to differentiate from pancreatic adenocarcinoma without definitive pathological diagnosis. PPL are much more amenable to treatment compared with pancreatic adenocarcinoma and correct diagnosis is crucial given that PPL has different managing and prognosis [5, 6]. It is important to diagnose PPL because of its better prognosis and also a different management strategy in comparison with pancreatic adenocarcinoma. This report describes an interesting case of primary pancreatic lymphoma.

CASE REPORT

A 38-year-old smoker man with IVDU (intravenous drug using) and history hepatitis of B (inactive carrier), C (Ia genotype) and negative for HIV was admitted to our hospital because of nausea, vomiting, epigastric and RUQ (right upper quadrant) pain as a result of long period of alcohol consumption. He took two periods treatment for C hepatitis with viral load 327000 IU/ml. Unlike the first period, the second period was complete. PEG-IFN and RBV were taken from patient who had no response. Also his wife had B hepatitis and takes lamivudine. Due to high amount of amylase (480 U/L; normal value: 30-110 U/L)

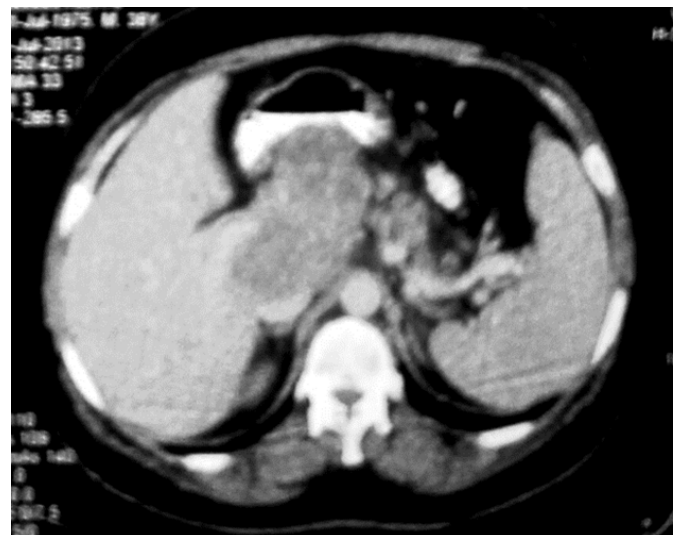


Figure 1. CT four days after admission showed enhancement a large tumor of the head of the pancreas.

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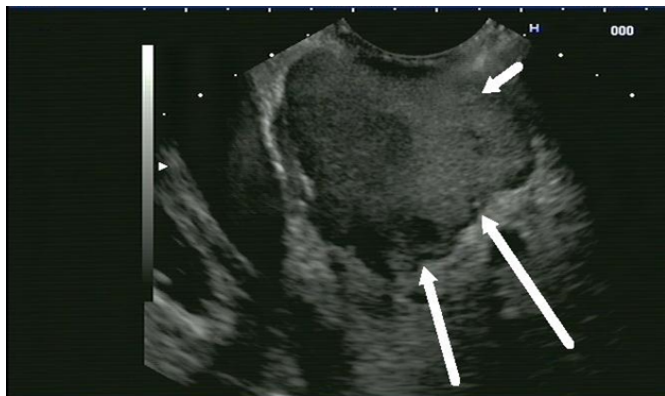


Figure 2. Diffusely enlarged of pancreas and echoic mass lesion 37-50 mm at the head of pancreas (R/O walled off necrosis) with adhesion to portal vein and SMV.

and lipase (326 U/L; normal value: 7-60 U/L) Pancreatitis is diagnosed. Four days after admission CT was done that showed enhancement a large tumor of the head of the pancreas (Figure 1).

Endoscopic ultrasound (EU) (Figure 2) revealed diffusely enlarged of pancreas. There was a mixed echoic mass lesion 37-50 mm at the head of pancreas (R/O walled off necrosis) with adhesion to portal vein and SMV (superior mesenteric vein). On the other hand the CBD (common bile duct) was 9 mm.

After early improvement, the patient was discharged against medical advice. Two months later, due to jaundice, itching and loss weight the patient returned again. The patient's laboratory findings on admission included: AST 60 IU/L (normal range <40), ALT 45 IU/L (normal range <40), ALP 520 IU/L (normal range <270), ferritine 204 ng/ml (normal range: 12-160 ng/ml), bilirubin-T 18.5 mg/dl (normal range: 0.2-1.3 mg/dl), bilirubin-D 8.3 mg/dl (normal range: <0.3 mg/dl), ESR-1st hr 32 mm/hr (normal range: 0-22 mm/hr), CRP-quantitative 20 mg/L (normal range: 0-10mg/dL), CEA 0.6 ng/ml (normal range: <5µg/L in smokers), Alpha-FP 2.6 ng/ml (normal range: <10 µg/L), CA 19-9 15 U/ml (normal range: <37 U/mL), CA 125 5 U/ml (normal range: <35 U/ml), PT- patient 13 seconds (normal range: 12-14 seconds) and PT-control 12 sec, INR 1.14 (normal range: 0.9- 1.1).

Abdominal MRI (Figure 3) and MRCP (Figure 4) for patient were done. The intra-hepatic bile ducts, main hepatic ducts, CHD and CBD are mildly dilated and displaced to the right side by a large lobulated mass (160×112×130 mm) of pancreatic head with low signal intensity on T1W images and high intensity on T2W images.

Region with multiple surrounding lymph nodes (up to 20 mm) compressing portal hepatic and encasing celiac trunk branches without stenosis. The pancreatic duct is only mildly dilated. The spleen has enlarged (170 mm). According low signal intensity on T1W images a 19 mm left adrenal mass detected; it could be an adrenal adenoma.

Endoscopic retrograde cholangiopancreatography (ERCP) for the patient was done and CBD stent used. In continue we did EUS-FNA (Figure 5) and there was a mixed echoic

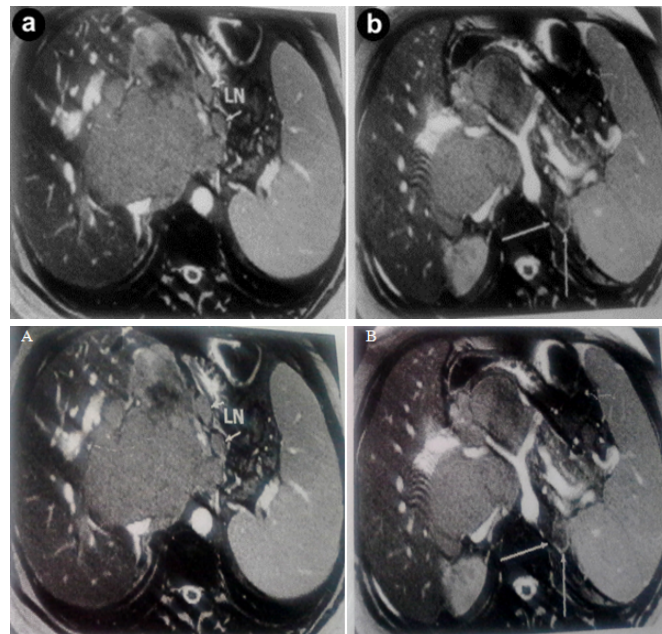


Figure 3. The intra-hepatic bile ducts, main hepatic ducts, CHD, CBD are mildly dilated and displaced to the right side by pancreatic head mass(160×112×130mm) on T1W and T2W images.

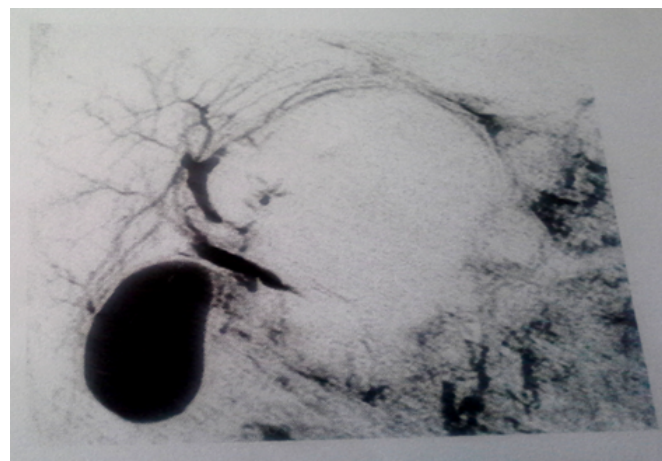


Figure 4. MRCP has shown pancreatic head mass (160×112×130mm) and mild dilatation of intra-hepatic bile ducts, main hepatic ducts, CHD and CBD. Region surrounded by multiple lymph nodes (up to 20 mm).



Figure 5. EUS-FNA indicated echoic lesion adhered to head of pancreas with invasion to portal vein, SMA and SMV.

lesion adhered to head of pancreas with invasion to portal vein, SMA (superior mesenteric artery) and SMV.

Pathological examination (Figure 6) of the prepared cell block from the pancreas tumor indicated sheet of small

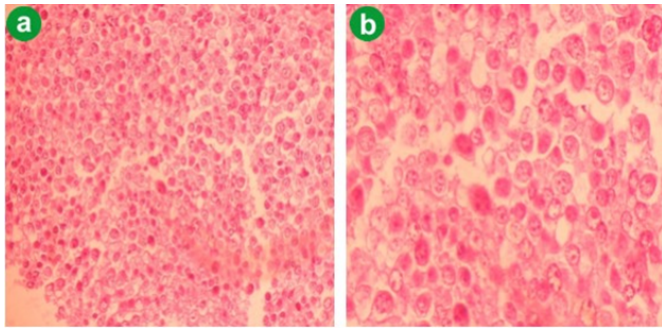


Figure 6. The neoplasm is composed of many small round cells with moderate anisonucleosis (H&E).

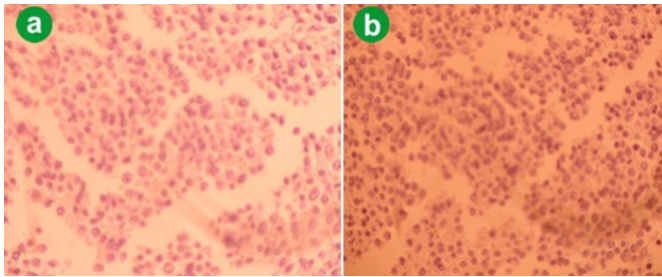


Figure 7. The cytokeratin (A) and CD3 (B) marker are negative in pancreas tumor cell.

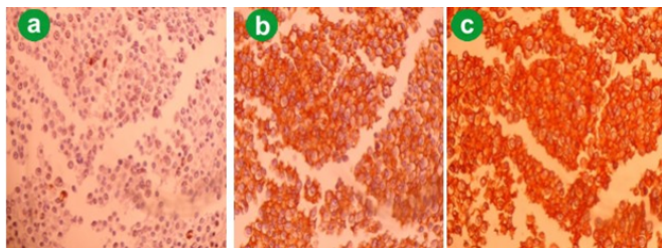


Figure 8. The cell proliferation marker Ki-67 (A), CD20 (B) and LCA (C) were positive in pancreas tumor cell.

round cells with moderate anisonucleosis. Many isolated cells having enlarged vesicular nuclei with distinct nucleoli. The chromatin pattern is coarse and the nuclear membrane is smooth mitotic figures are easy to find. Back ground is blood rich. According EUS guided needle aspiration of pancreatic head (cell block section) the presence of small round cells tumor Indicating lymph proliferative disorder and IHC study is mandatory to confirm the diagnosis.

The immunohistochemical studies were performed using antihuman antibodies against the following markers: Unlike cytokeratin and CD3 (Figure 7) that were negative in tumor cell, LCA, Ki67 (in 5 % of tumor cells) and CD20 strongly were positive in tumor cells (Figure 8).

The diagnosis of pancreatic lymphoma was established by immunohistochemical study and the assessment of the neoplastic cells revealed B cell lymphoma phenotypes.

DISCUSSION

Pancreatic lymphoma is categorized as a nonepithelial tumor of the pancreas [7]. It is most commonly a B-cell sub-type of non-Hodgkin lymphoma and is classified as either primary or secondary. PPL is a rare extranodal manifestation of any histopathological subtype of B-cell non-Hodgkin's lymphoma, representing less than 1- 2% of

extranodal lymphomas and 0. 5% of pancreatic tumors [8, 9]. Volmar et al found 14 cases (1. 3%) of PPL in biopsy of 1050 cases of pancreatic mass lesions [10]. In a review of 207 cases of malignant pancreatic tumors, there were only 3 cases (1. 5%) of pancreatic lymphoma [11]. The symptoms may be nonspecific, but can include abdominal pain, weight loss, night sweats, and small bowel obstruction. Bellyache and abdominal mass are two major symptoms which present in 83% and 58% of PPL cases, respectively [12, 13]. Also mild alteration of the main pancreatic duct and elevation of serum amylase levels may be observed but the clinical manifestation of pancreatitis is infrequent. Lymphomatous involvement of the ampullary channel and common bile duct may cause stenosis and strictures [14]. The proximity of the liver to the pancreas and the fact that the liver and pancreas share common blood vessels and ducts may make the pancreas another potential target organ for hepatitis viruses. Diagnostic criteria for PPL, was defined by Dawson et al. [15-17] include: 1. neither superficial lymphadenopathy nor enlargement of mediastinal lymph nodes on chest radiography; 2. a normal leukocyte count in peripheral blood; 3. main mass in the pancreas with lymphnodal involvement confined to per pancreatic region; and 4. no hepatic or splenic involvement. Abdominal pain, weight loss, nausea, vomiting, jaundice, acute pancreatitis, and small bowel obstruction are the non-specific symptoms of PPL [18].

In fact hepatitis B surface antigen(HBsAg), a marker for chronic HBV infection, was detected in pure pancreatic juice and bile[19]. This finding was later supported by studies showing evidence of HBV replication in pancreatic cells and concurrent damage to exocrine and endocrine epithelial cells with an inflammatory response[20, 21]. It was observed an association between past exposure to HBV and risk for pancreatic cancer development[22]. Hepatitis C virus (HCV) infection has been associated with the development of B cell NHL (including diffuse large B cell lymphoma, marginal zone lymphoma and extranodal marginal zone B cell lymphoma of mucosa-associated lymphoid tissue)[23, 24]. It is important to PPL differentiated from pancreas adenocarcinoma because they have different management. Imaging results play a key role in diagnosis of PPL. Percutaneous ultrasound (US), endoscopic ultrasonography (EUS), computed tomography (CT), MRCP and MRI are well-established procedures to evaluate pancreatic masses [25-28]. Although certain serum abnormalities and CT changes are suggestive of lymphoma, tissue examination is essential for diagnosis. Patients presenting with advanced disease may be diagnosed by peripheral lymph node FNA, core or open biopsy [5, 29]. Histological analysis is crucial for differentiating between adenocarcinoma and lymphoma of the pancreas and treatment planning of patient. Investigation of histological marker such as CD20, CD3 and Ki67 can be useful [14, 30]. Also serum carbohydrate antigen 19-9 (CA 19-9) level in patients with PPL is usually not elevated. This is in contrast with pancreatic adenocarcinoma, in which almost 80% of cases have a

high CA19-9 level [31]. Treatment options contain surgical resection, chemotherapy alone, or combined radiation and chemotherapy. Response rates to chemotherapy alone are very good, with approximately 72% of patients showing no evidence of disease at 34 months [13, 32].

Conflicts of Interest

The authors declare that they have no conflict of interest

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