ISOLATED PERIPANCREATIC TUBERCULOUS LYMPHADENITIS MIMICKING AS PANCREATIC MALIGNANCY

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Abstract

Tuberculosis (TB) is a chronic bacterial infection, commonly seen in developing countries. Abdominal tuberculosis (TB) is the sixth most common location of extrapulmonary TB involvement. Pancreatic and peripancreatic tuberculosis is difficult to diagnose and often misdiagnosed as pancreatic carcinoma due to non-specific symptoms and similar tissue density on imaging. We present a case of Isolated Peripancreatic Tuberculous Lymphadenitis, its atypical presentation, diagnostic approach, and treatment aspects. A 17- yr old male presented to us with complaints of abdominal pain, generalised pruritus and decreased appetite for 2 months. He had undergone an ultrasonogram of the abdomen which showed a mass in the head of the pancreas. CT scan of the abdomen revealed an ill-defined, heterogeneously enhancing mass with few necrotic and cystic areas epicentered in the region of hepatoduodenal ligament, completely encasing and compressing the major structures of the porta hepatis. His CA 19-9 levels were within normal limits. Hence, we performed an Endoscopy ultrasound- guided Fine-needle aspiration cytology (EUS-FNA) which showed necrotising granular inflammation of tuberculous aetiology. After confirming a diagnosis of pancreatic tuberculosis, he was started on antitubercular therapy to which he responded well and recovered completely within 9 months.

Introduction

- ❑ Pancreatic and peripancreatic tuberculosis is very rare.
- ❑ Prevalence is equal in both sexes, more common in young adults.
- ❑ In 30% of cases, there's history of Pulmonary tuberculosis.

Case Report

- A 17 year old male presented with abdominal pain, generalised pruritus and decreased appetite since 3 months
- It was dull pain in his epigastric region with no radiation.
- No fever, weight loss or change of bowel habits.
- He denied any history of smoking, alochol consumption, drug abuse, high risk sexual exposure.
- There was no significant past, family, contact history.

Clinical Findings

- ➢ On general examination he had Icterus and palor.
- ➢ Chest was clear, no enlarged cervical Lymph nodes.
- ➢ Per abdomen examination: No palpable lump or ascites.

Laboratory Values

Tests	Values
Hb	8.7
TLC	6.67
T. Bili	3.23
ALP	1065
AST	180
ALT	134
CA 19-9	5.96
CEA	1.87

Radiological Findings

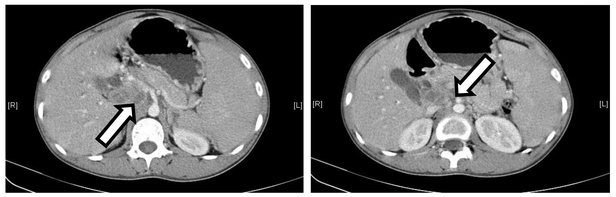
Chest X-ray

His Chest X-ray was interpreted as normal.

Ultrasonography

- ❖ A cystic mass was seen arising from the head of the pancreas
- ❖ Gall bladder was distended along the entire course.

CT Scan

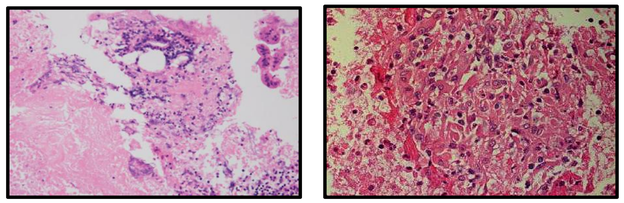


- ✓ An ill defined, heterogeneously enhancing mass with few necrotic areas was seen in the region of hepatoduodenal ligament.
- ✓ The mass was abutting the head of pancreas, second and third parts of duodenum were pushed laterally.
- ✓ Mass was completely encasing and compressing the porta hepatis and features of thrombosis were noted with periportal collaterals.
- ✓ In view of young age and normal tumor marker levels, overall imaging features favored infective origin.

Endoscopic Ultrasonograpgy

- ➢ A hypoechoic 2.7 cm lesion was seen abuting the head of pancreas.
- ➢ The mass was comprised of a conglomerated lymph node encasingthe portal vein leading to formation of multiple periportal collaterals.
- ➢ Multipass Fine needle aspiration was taken under Endoscopic ultrasonography guidance.
- ➢ The adequacy of sample was tested by ROSE (rapid on-site evaluation) technique.

Histopathological findings



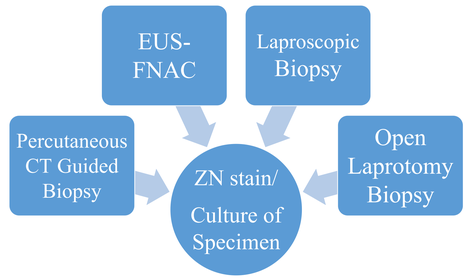
- H & E Stained slide showed presence of pancreatic acinar cells in a necrotic background.
- Few ill defined epitheloid cell granulomas with multinucleated gaint cells were also seen.
- Tuberculous aeitology was confirmed.

Differential Diagnosis

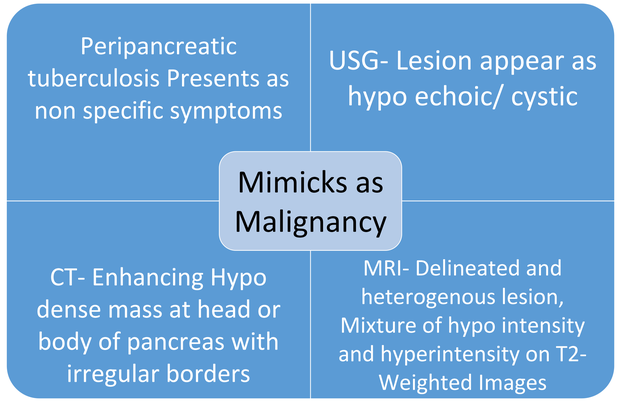
Pancreatic mass lesions with peripancreatic lymphadenopathy include the following differentials:

- Malignant lymphoma
- Whipple's disease
- Malignant neoplasm
- Chronic Pancreatitis

Investigation Modalities



Mimicking Malignancy



Management

- Patient underwent ERCP and Biliary stenting for Obstructive Jaundice
- He was started on anti tubercular drugs. He was followed up after 9 months of treatment, the mass had resolved complteley

Conclusion

- ❑ Tuberculosis should be considered in young patients in the endemic regions presenting with periportal lymph nodes with or withoutintrapancreatic mass.
- ❑ In tuberculous peripancreatitis non surgical management is the preferred modality of treatment.

References

1. T. A. Sheer and W. J. Coyle, “Gastrointestinal tuberculosis,” Current Gastroenterology Reports, vol. 5, no. 4, pp. 273–278, 2003.
2. H. Jadvar, R. E. Mindelzun, E. W. Olcott, and D. B. Levitt, “Still the great mimicker: abdominal tuberculosis,” American Journal of Roentgenology, vol. 168, no. 6, pp. 1455–1460, 1997.
3. J. V. Cherian, A. Somasundaram, R. P. Ponnusamy, and J. Venkataraman, “Peripancreatic tuberculous lymphadenopa-thy. An impostor posing diagnostic difficulty,” Journal of the Pancreas, vol. 8, no. 3, pp. 326–329, 2007.
4. Naouri A, Tissot E : Isolated tuberculous retroduodeno-pancreatic adenopathy simulating a pancreatic tumour: A case report. Ann Chir 1990;44:480–483.
5. Zacharia GS, Ramachandran TM. Isolated pancreatic tuberculosis masquerading as pancreatic cancer. Gastroenterol