JOP. J Pancreas (Online) 2004; 5(3):145-147.

CASE REPORT

Co-Existence of Peri-Ampullary Carcinoma with Peripancreatic Tuberculous Lymphadenopathy

Chirag S Desai[1], Murad Lala[1], Anand Joshi[2], Philip Abraham[2], Devendra Desai[2], Ramesh B Deshpande[3], Sudeep R Shah[1]

[1]Departments of Surgery, [2]Gastroenterology and [3]Surgical Pathology, PD Hinduja Hospital and Medical Research Center. Mumbai, India

ABSTRACT

Context Pancreatic tuberculosis and peripancreatic tuberculous lymphadenitis are rare, mimicking various pathologies of the pancreas. The coexistence of peri-ampullary malignancy with peripancreatic tuberculous lymphadenitis has not been reported.

Case report We present the case of a young woman who had been operated on with a preoperative diagnosis of peri-ampullary adenocarcinoma in whom a frozen section of regional lymph nodes revealed tuberculosis. The final pathology confirmed the co-existence of tuberculosis with malignancy. The patient made an uneventful recovery.

Conclusion In countries with high endemicity for tuberculosis, the co-existence of malignancy and tuberculosis should be considered and resection, which is the only chance for cure, should not be abandoned due to observations based solely on frozen sections.

INTRODUCTION

Pancreatic tuberculosis and peripancreatic tuberculous lymphadenitis are rare clinical entities. Pancreatic tuberculosis often mimics pancreatic cancer, pancreatic abscess, cystic tumors of the pancreas, pseudocysts of the pancreas or chronic pancreatitis with head mass on preoperative non-invasive diagnostic tests [1]. Peripancreatic tuberculous lymphadenitis mimicking pancreatic pseudotumor is also reported in the literature [2]. However, the coexistence of peri-ampullary malignancy with peripancreatic tuberculous lymphadenitis has not been reported. We report the case of a young woman presenting with peri-ampullary carcinoma associated with tuberculous peripancreatic lymphadenitis.

CASE REPORT

A 28 year old woman presented with jaundice, pruritus and alcoholic stools alternating with melena of one month duration. She had had abdominal pain with radiation to the back and vomiting for one year. She had lost significant weight in the month before. On examination, she had icterus, scratch marks and palpable gallbladder.

On admission, serum total bilirubin was 11.3 mg/dL (reference range: 0.2-1.0 mg/dL), direct bilirubin was 6.9 mg/dL (reference value: less than 0.3 mg/dL) and alkaline phosphatase was 469 IU/L (reference range: 40-120 IU/L). Ultrasonography and a CT scan showed dilatation of the intra and extrahepatic biliary tree and the pancreatic duct but only

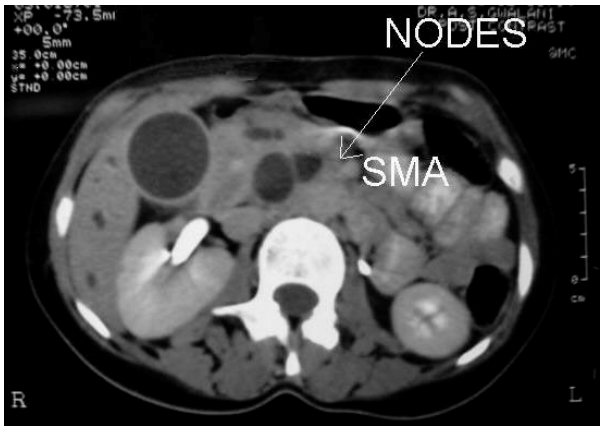

Figure 1. CT scan of the abdomen showing a dilated bile duct and small nodes adjacent to the superior mesenteric artery (SMA).

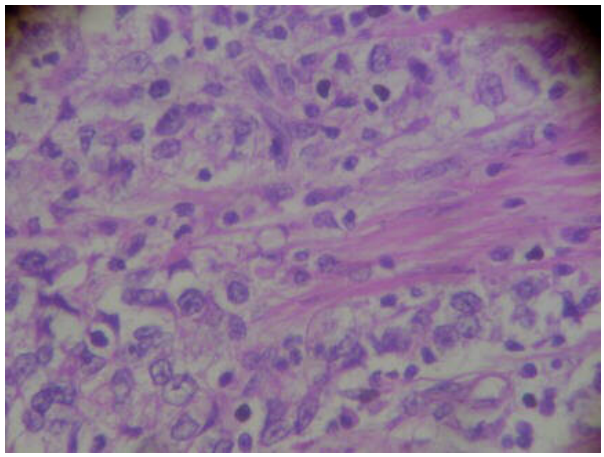

Figure 3. Histopathology of the ampullary mass; poorly differentiated adenocarcinoma

small lymph nodes (Figure 1). There was no mass in the head of the pancreas. Side-viewing endoscopy revealed an infiltrating growth in the peri-ampullary region extending to the first part of the duodenum. Cannulation of either duct was not possible. Brush cytology and mucosal biopsy revealed adenocarcinoma.

Intraoperatively, there was no evidence of liver or peritoneal metastasis. A mass was palpable in the peri-ampullary region. There was extensive peripancreatic lympha-denopathy (Figure 2). A frozen section of these nodes suggested tuberculosis. Whipple's procedure was performed in view of the earlier biopsy report of adenocarcinoma. Her postoperative recovery was uneventful. She was discharged on four-drug antituberculous therapy and was doing well on follow-up two months later.

Histopathology confirmed high-grade adenocarcinoma in the peri-ampullary region (Figure 3) infiltrating transmurally, reaching up to the serosa and infiltrating pancreatic lobules peripherally. A peripancreatic lymph node showed multiple caseating epitheloid granulomas with Langhans' type giant cells (Figure 4).

DISCUSSION

The incidence of pancreatic tuberculosis is very low. Even in the presence of miliary tuberculosis, pancreatic tuberculosis accounts for 0-4.7% of cases of abdominal tuberculosis [3, 4]. Pancreatic tuberculosis often mimics

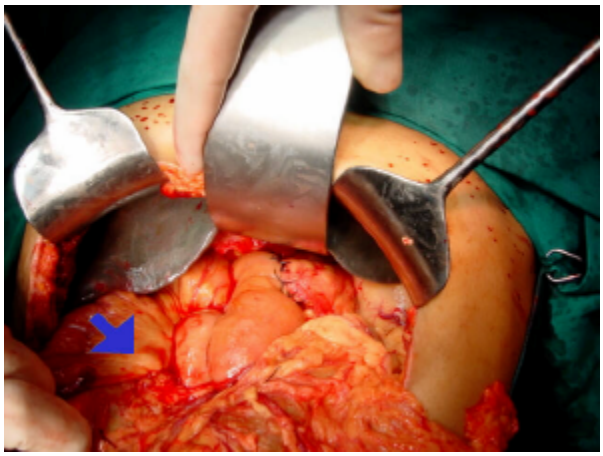

Figure 2. Intraoperative photograph following roux loop pancreaticojejunostomy showing an enlarged node in the bowel mesentery (arrow).

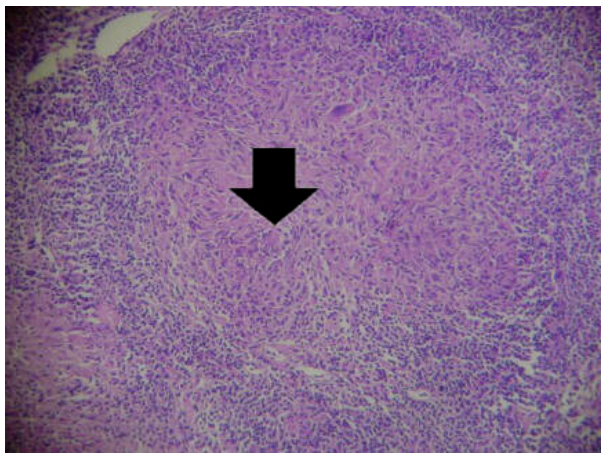

Figure 4. Histopathology of the lymph node showing caseating necrosis and Langhans' type giant cells (arrow).

various pathologies. In the majority of patients, the diagnosis is obtained at laparotomy [5, 6]. There are few reports in literature mentioning isolated peripancreatic and retroduodenal tuberculous lymphadenopathy simulating a pancreatic tumor [2, 7], but no evidence of the coexistence of both [1].

Turan *et al*. [2] reported a case in which a frozen section of a lymph node was inconclusive and, hence, Whipple's procedure was performed; histopathology suggested tuberculosis. On the other hand, laparotomies have been abandoned on the basis of histology suggestive of tuberculosis [8]. In our case, since we had pre-operative brush cytology and biopsy, even though frozen sections of peripancreatic nodes were suggestive of tuberculosis, surgery could be proceeded with.

In countries with high endemicity for tuberculosis, the co-existence of malignancy and tuberculosis should be considered and resection, which is the only chance for cure, should not be abandoned due to observations based solely on frozen sections. If preoperative or intraoperative biopsies are suggestive of this benign pathology, careful follow-up imaging is essential to show regression of the mass on anti-tuberculosis therapy; failing this, the surgical option should be revisited.

Received October 27th, 2003 - Accepted January 26th, 2004

Key words Adenocarcinoma; Mycobacterium tuberculosis; Pancreas; Pancreatic Neoplasms; Tuberculosis; Tuberculosis, Gastrointestinal; Tuberculosis, Lymph Node

Correspondence
Sudeep R Shah
PD Hinduja National Hospital
Veer Savarkar Marg
Mahim
Mumbai, 400 016
India
Phone: +91-22 2444.7126
Fax: +91-22.2444.0425
E-mail address: shahsudeep@hotmail.com

References

1. Chaudhary A, Negi SS, Sachdev AK, Gondal R. Pancreatic tuberculosis: still a histopathological diagnosis. Dig Surg 2002; 19:389-92. [PMID 12435910]

2. Turan M, Sen M, Koyuncu A, Aydin C, Elaldi N, Arici S. Pancreatic pseudotumor due to peripancreatic tuberculous lymphadenitis. Pancreatology 2002; 2:561-4. [PMID 12435870]

3. Bhansali SK. Abdominal tuberculosis. Experience with 300 cases. Am J Gastroenterol 1977; 67:324-37. [PMID 879148]

4. Auerbach O. Acute generalized miliary tuberculosis. Am J Pathol 1944; 210:121-36.

5. Evans JD, Hamanaka Y, Olliff SP, Neoptolemos JP. Tuberculosis of the pancreas presenting as metastatic pancreatic carcinoma. A case report and review of the literature. Dig Surg 2000; 17:183-7. [PMID 10781988]

6. Sanabe N, Ikematsu Y, Nishiwaki Y, Kida H, Murohisa G, Ozawa T, et al. Pancreatic tuberculosis. J Hepatobiliary Pancreat Surg 2002; 9:515-8. [PMID 12483276]

7. Naouri A, Tissot E. Isolated tuberculous retro-duodeno-pancreatic adenopathy simulating a pancreatic tumour: A case report. Ann Chir 1990; 44:480-3. [PMID 2221796]

8. Pramesh CS, Heroor AA, Shukla PJ, Jagannath PM, De Souza LJ. Pancreatic tuberculosis. Trop Gastroenterol 2002; 23:142-3. [PMID 12693159]