Patho Corner

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Case 1

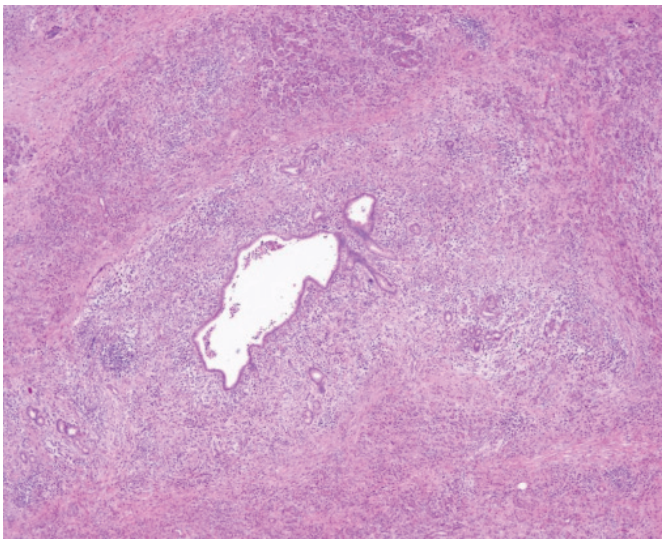
A 59 years old male presented with epigastric discomfort that increase in severity when lying down for 2 months. He had jaundice for 1 month. CT upper abdomen revealed a mass at pancreatic head with dilatation of pancreatic duct and common bile duct. The ERCP showed distal common bile duct obstruction with upstream dilatation of common bile duct, common hepatic duct and intrahepatic ducts.

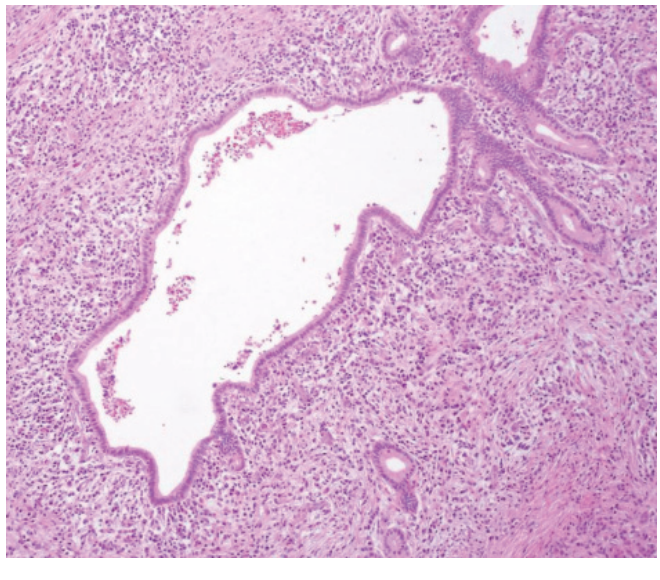
The patient was treated by standard biliary sphincterotomy with double pigtailed stent inserted in across the stricture. Whipple's operation was successfully performed and pathological reported: (Figure 1-3)

(a) dense circumferential lymphoplasmacytic infiltration within and around the pancreatic ducts, especially the medium-sized, interlobular and main pancreatic ducts.

(b) prominent sclerotic collagen bundles with lymphoplasmacytic infiltration. Lymphoplasmacytic infiltration and sclerosis with parenchymal atrophy in the pancreatic lobuli.

On immunohistochemistry, plasmacytes show various degrees of positivity for IgG4. (Figure 4)





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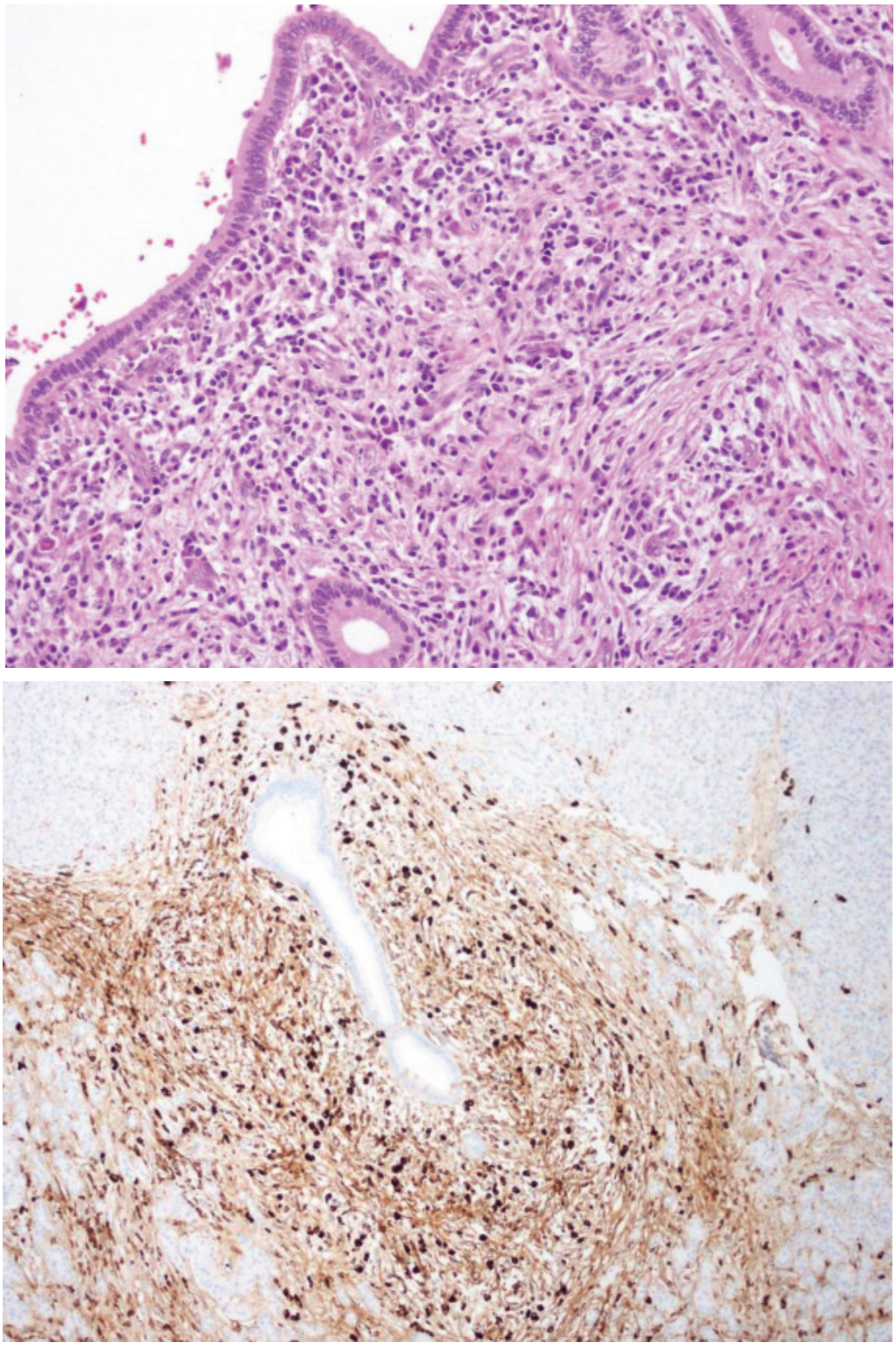


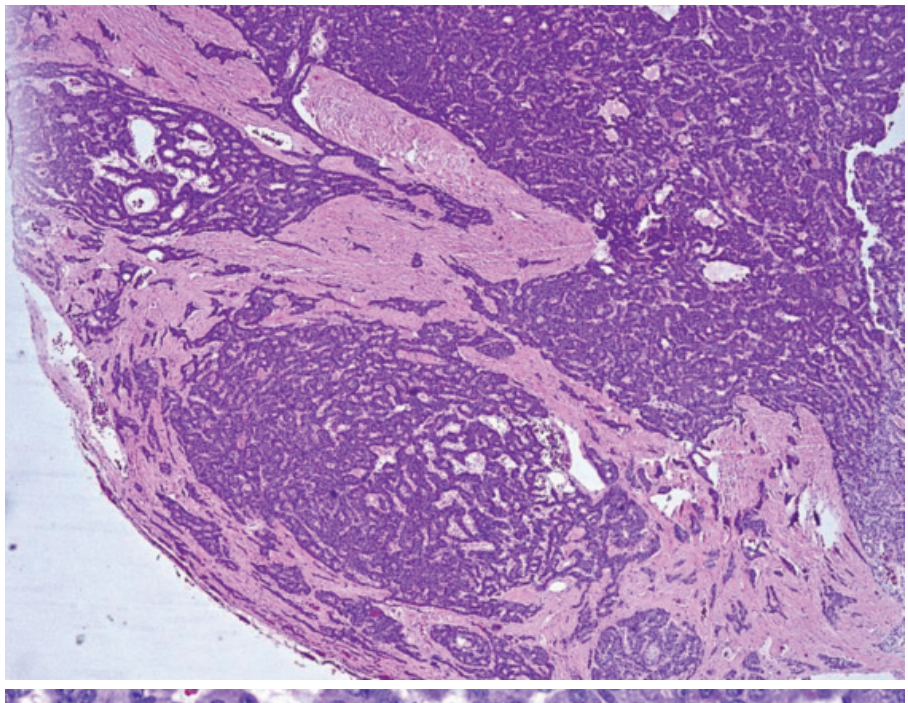
Figure 1-4.

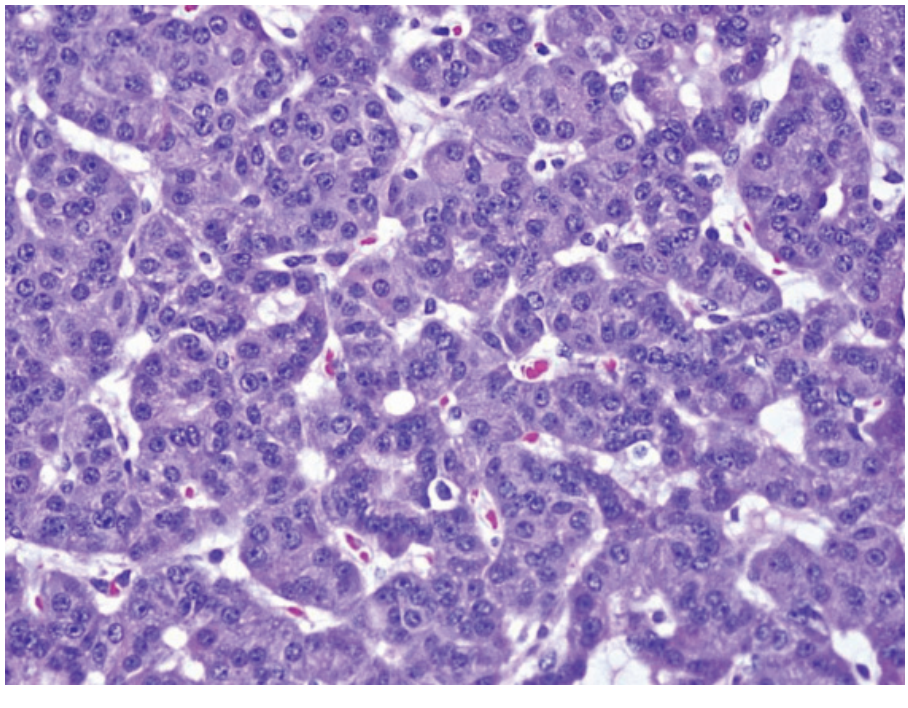
What is the most likely diagnosis?

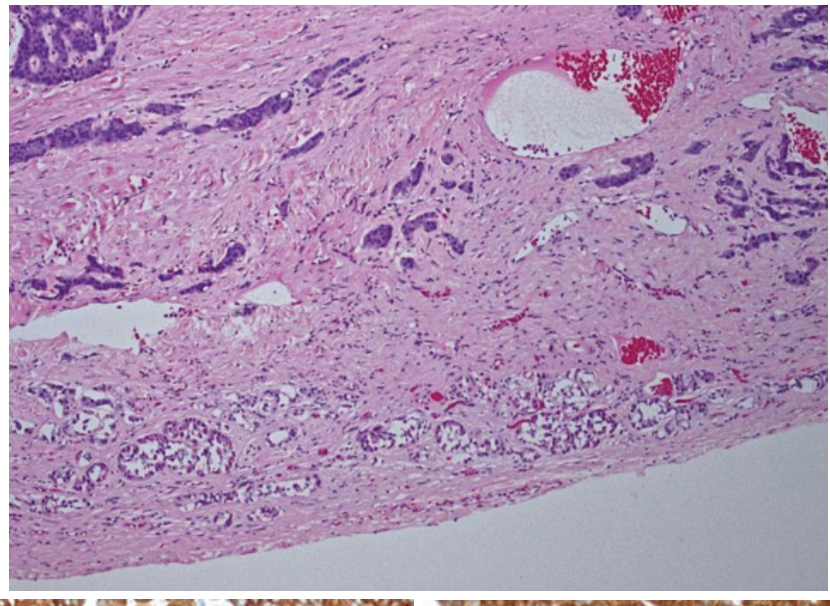
(Answer see page)

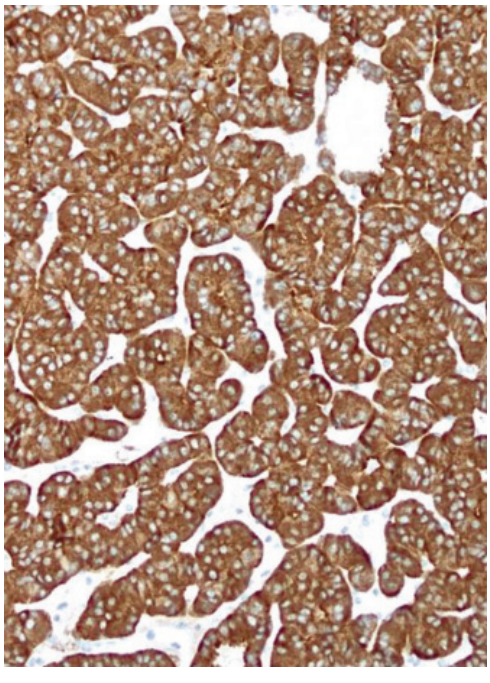
Case 2

A 58-year-old male presented with midepigastric and left upper quadrant abdominal pain. Past medical history included gastroesophageal reflux disease (GERD) and hyperlipidemia. Vital signs on admission were stable. Computed tomography (CT) of the abdomen found large cystic tumor at body of pancreas. An endoscopic ultrasonography (EUS) was performed and showed a solid tumor (4x5 cm.) containing some area of cystic degeneration. Serum measurements of CA19-9, carcino embryonic antigen (CEA), and alpha-fetoprotein (AFP) were found to be within normal limits. The patient underwent distal pancreatectomy and pathology result was pancreatic mass with atrophic pancreatic acini intervening with fibrotic background. Tumor cells possess stipple nuclei and arrange in trabecular pattern among thin-walled vessels (Figure 5-7). Tumor cells display diffusely positive CgA and Synaptophysin. Ki67 is less than 2% (Figure 8-10).

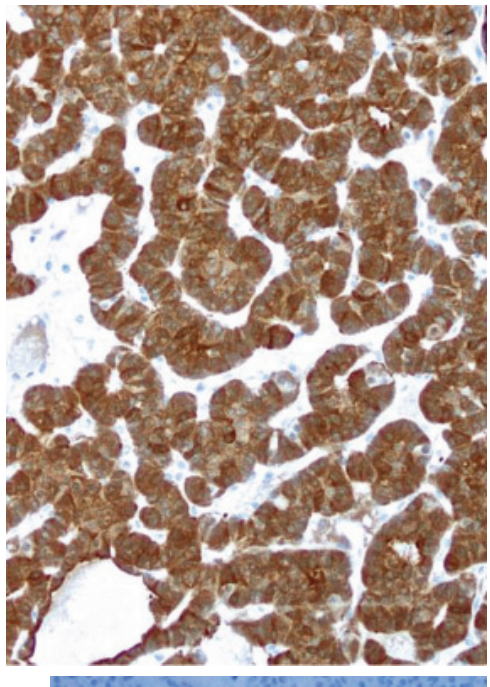








Chromogranin A



Synaptophysin

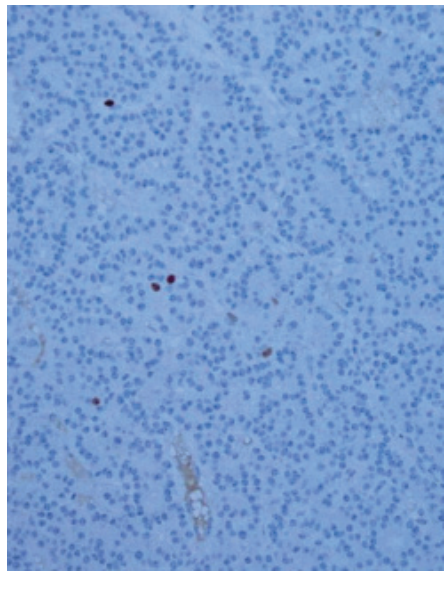


Figure 5-10.

What is the most likely diagnosis ?

(Answer see page)

Case 3

A 60-year-old man underwent a medical examination for dyspeptic symptom and incidentally found mass at the pancreatic body on ultrasonography. His family history was unremarkable. In the laboratory examination, the liver function test, white blood cell (WBC) count and tumor markers (carcinoembryonic antigen and carbohydrate antigen 19-9) were within the normal limits.

CT scan of the abdomen showed dilatation of main pancreatic duct at the head and neck of pancreas. There was an abnormal papillary-like soft tissue projection along the pancreatic duct. The operation was performed. Pancreatic specimen from Whipple's operation reported dilated main pancreatic duct lined by mucinous epithelium with low grade dysplasia, no malignant transformation seen, and no angiolymphatic invasion seen (Figure 11-13).

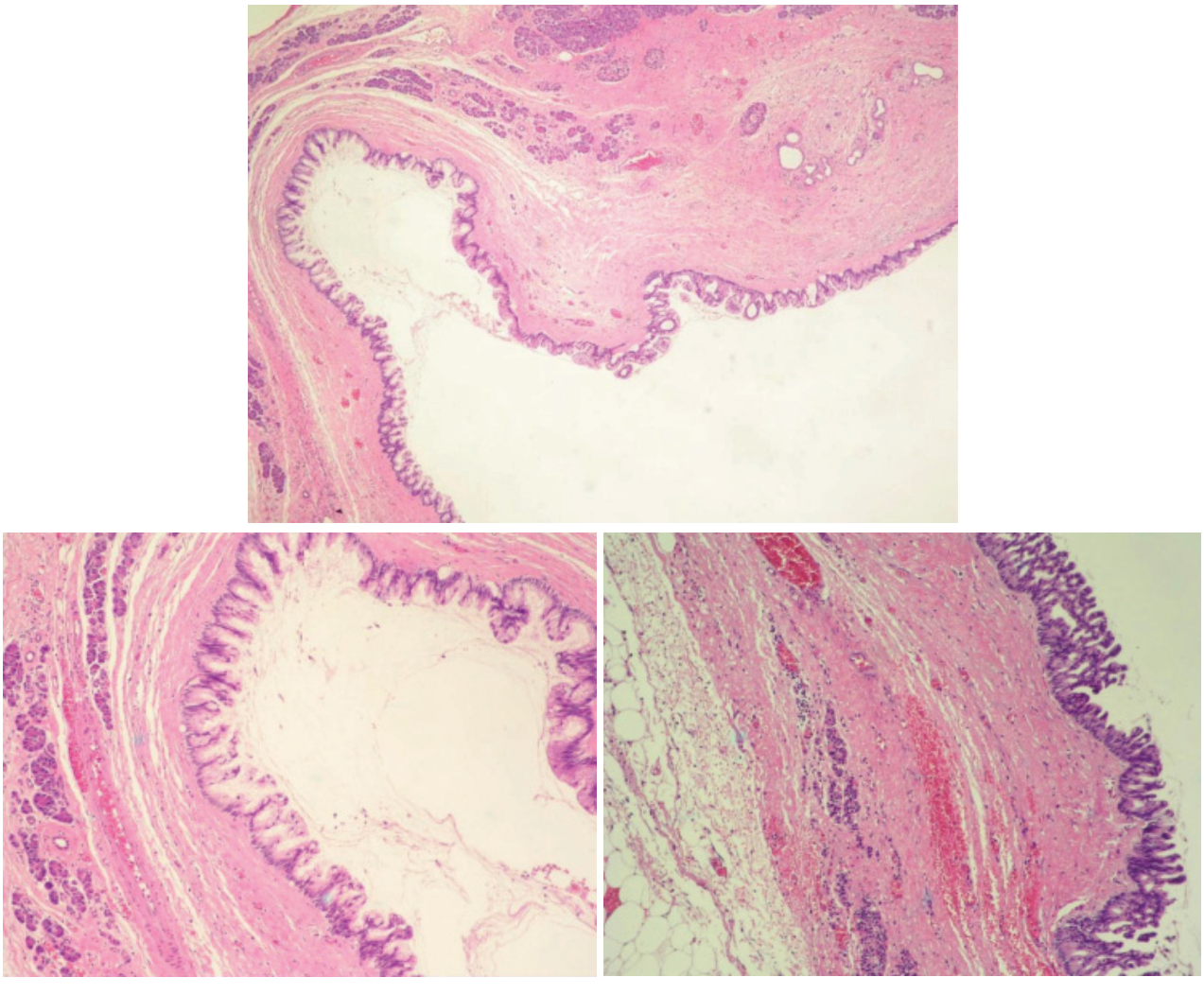


Figure 11-13.

What is the most likely diagnosis?

(Answer see page)

Answer for patho corner

Case 1 = AIP (Lymphoplasmacytic sclerosing pancreatitis)
Case 2 = Pancreatic mass, well differentiated neuroendocrine tumor, grade I
Case 3 = Intraductal Papillary Mucinous Neoplasms (IPMNs) with low grade dysplasia