

Metachronous pancreatic ductal adenocarcinoma after remission of autoimmune pancreatitis

성균관대학교 의과대학 삼성서울병원 내과

*백송인, 이광혁

Autoimmune pancreatitis (AIP) is rare disease that there have been no report about pancreatic cancer which occurs after remission of AIP in Korea. Here we report a case of pancreatic cancer developed 2 years after remission of AIP in same lesion. A 60-year-old man was admitted with abdominal pain on November 2013. CT showed 2.9cm mass in pancreas uncinated process which did not show mass effect. There was no biliary tree or main pancreatic duct obstruction. It suggested that the mass was AIP rather than pancreatic cancer. The serum level of CA19-9, CEA were 6.31U/l, 1.13ng/ml, respectively. The level of IgG4 was elevated(203mg/dl). EUS-FNA was performed and there was reactive cellular changes associated with chronic pancreatitis and the immunohistochemistry for IgG4 was negative. He was treated with 40mg of prednisolone for 4 weeks. After 4 weeks, mass size was decreased in CT. The patient was diagnosed as AIP according to HISORt criteria. The dose of prednisolone was tapered gradually over 16 weeks. After the treatment, CT showed no demonstrable focal lesion in pancreas. And follow-up CT after 1 year also showed no focal lesion. He was considered as remission. On June 2016, the patient visited again with jaundice. Low-attenuated lesion in same location of uncinated process was increased and biliary tree dilation was aggravated in CT. ERCP was performed and the cytology showed atypical ductal cells. To differentiate from AIP, CT was conducted again after treatment with prednisolone for 4 weeks. The follow-up CT taken after treatment showed no changes in low density mass. EUS-FNA was re-performed and ductal adenocarcinoma was diagnosed. PET showed hypermetabolic mass in pancreas and suspicious hypermetabolic lymph node in left supraclavicular area. FNA was performed for lymph node, and the result was positive with metastatic carcinoma. 11 cycles of FOLFIRINOX was done. After chemotherapy, the patient underwent selective neck dissection and pylorus resecting pancreaticoduodenectomy followed by adjuvant FOLFIRINOX. **Conclusion:** When recurrence of AIP is suspected, pancreatic cancer should be considered in the differential diagnosis. Close follow-up examination is important for AIP even after the remission.

Endoscopic Treatment of Main Pancreatic Duct Disruption

한일병원

* 이창균, 윤병우, 김동춘

Main pancreatic duct disruption is a serious condition, where without treatment, the prognosis is fatal. Even though surgery is the most common treatment modality, the mortality and morbidity rate is high due to its extensive excision extent. Herein, we report a rare case of main pancreatic duct disruption, successfully treated with a pancreatic duct stent during endoscopic retrograde cholangiopancreatography (ERCP). A 48-years-old man with a history of chronic alcoholism visited the emergency room due to abdominal pain. Laboratory findings showed normal WBC and liver enzymes, although lipase and amylase were elevated. Abdominal computed tomography (CT) showed a small amount of peripancreatic fluid collection. Diagnosed with acute pancreatitis due to alcohol intake, he was discharged 1 week after admission without complications. However, he revisited the emergency room within two weeks, with the same symptoms, denying alcohol intake after discharge. His laboratory findings were similar as the first admission, but his abdominal CT presented with increased peripancreatic fluid collection extended around the pancreas head, liver, right kidney and a new pancreatic pseudocyst of 2.5 cm in diameter. As the patient's symptoms deteriorated, a magnetic resonance cholangiopancreatography was performed 2 weeks after, which could not rule out pancreatic duct disruption. Hence, an ERCP was performed, proving pancreatic duct disruption with leakage, which was treated by inserting a plastic stent in the pancreatic duct. This lead to a rapid improvement of the patient's symptoms and reduction of amylase and lipase. He was discharged 4 weeks after his second admission, and a follow-up ERCP 3 months after showed no pancreatic duct injury where the pancreatic stent was removed. A follow-up abdominal CT also showed no evidence of peripancreatic fluid collection and pancreatic pseudocyst. There have been many technical advancements in diagnosis and treatment of main pancreatic duct disruption. However, there is no established standard treatment. From this case, we present that ERCP can both diagnose and safely treat pancreatic duct disruption without complications, and possibly provide a standard treatment modality.