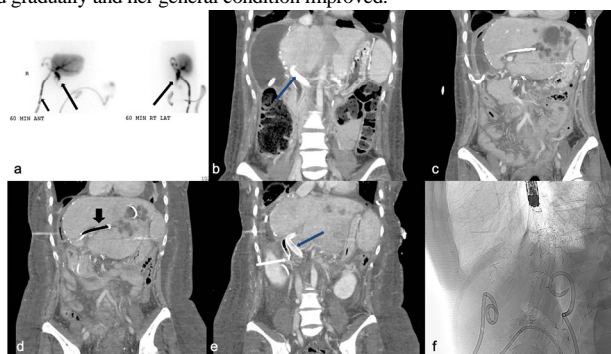


# A case of EUS-guided removal of proximally migrated malfunctioning biliary metal stent

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A 31-year-old woman presented with biliary leakage after recent hepatectomy. She underwent distal pancreatectomy due to 6cm-sized pancreatic neuroendocrine carcinoma 5 years ago and concomitant chemoradiation therapy and recently underwent right hepatectomy due to metastatic right hepatic mass from recurrent pancreatic neuroendocrine carcinoma. Bile-containing fluid was aspirated from surgical drain near hepatectomy site for 5 days and hepatobiliary scan showed biliary leakage. We inserted a biliary plastic stent from ampulla to left intrahepatic bile duct (IHD), but bile-containing fluid still aspirated continuously from surgical drain. Follow-up abdominal CT showed multiple hepatic abscesses in left lobe and percutaneous transhepatic biliary drainage (PTBD) was performed. Because aspirated fluid via PTBD catheter was bile-contained and similar from surgical drain near hepatectomy site, we exchanged the plastic stent to 10mm covered metal stent. After the procedure, inserted metal stent was inadvertently migrated deeply into common bile duct and not visible. The adjustment with traction of metal stent for proper position failed by multiple retrieval accessories including snare and balloon, but the distal tip of metal stent was changed in shape and compressed during the manipulation. Total bilirubin increased up to 10 mg/dL and Follow-up CT 7 days later after metal stent insertion showed similar multiple hepatic abscesses and previous PTBD catheter was exchanged to larger catheter. But, total bilirubin increased more and retrieval of revision with traction of the migrated stent from ampulla also failed. After we explained EUS-guided biliary drainage (EUSBD) to patient, we inserted large-caliber (14mm) metal stent from cardia of stomach for next removal of migrated metal stent under EUS guidance. The migrated metal stent could be remove through the sinus tract from stomach 10 days later and large-caliber metal stent (Plumber, MI Tech) was also removed. Total bilirubin level decreased gradually and her general condition improved.



# Precursor B-cell lymphoblastic leukemia presenting as pancreatic mass and skin lesion: A case report

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**Introduction:** Pancreatic infiltration is an uncommon manifestation of Precursor B-cell lymphoblastic leukemia. Jaundice and acute pancreatitis are rarely caused by involvement of the pancreas in adult patient with lymphoblastic leukemia. We report a case of Precursor B-cell lymphoblastic leukemia presenting as pancreatic mass with obstructive jaundice, pancreatitis and cutaneous lesions. **Case:** A 19-year-old female was admitted to our institute due to right upper quadrant pain with radiation to back, started about 2 weeks before the visit. Multiple palpable brownish nodules were also noted on the trunk and the back (Fig 1A). In the laboratory findings, aspartate transaminase, alanine aminotransferase were elevated to 679 IU/L and 1171 IU/L along with amylase and lipase which were 390 IU/L and 1244 IU/L, respectively. Computed tomography revealed 3.7cm sized mass in the head of pancreas with dilatation of bile duct and pancreatic duct (Fig 1B). Endoscopic retrograde cholangiopancreatography and biliary stenting were performed for reducing jaundice. Precursor B-cell lymphoblastic leukemia was diagnosed by skin punch biopsy and bone marrow biopsy. The patient received induction chemotherapy with combination of cyclophosphamide, daunorubicin, vincristine and dexamethasone. Follow-up computed tomography showed a reduction of the pancreatic head mass from 3.7 cm to 1.7 cm. After initial induction chemotherapy, a repeat bone marrow assessment showed a complete remission with no residual disease. **Conclusion:** Acute pancreatitis and obstructive jaundice can be caused by acute lymphoblastic leukemia. It should be considered as part of the differential diagnosis when atypical features are present.

