中文題目：腹部超音波及電腦斷層無法偵測之胰臟頭部腫瘤所引起之阻塞性黃膽

英文題目：Obstructive jaundice caused by pancreatic head tumor which could not be detected by abdominal sonography and CT

作　　者：林宜竑[1] 葉明倫[1] 莊萬龍[1] 黃尚志[1]

服務單位：高雄醫學大學附設醫院內科部[1]

Case presentation: This is a 52-year-old female with a history of hypertension and type 2 diabetes mellitus with follow-up regularly at our CV and endocrine clinic. 10 days before she came to our Emeregency department, she had right upper abdominal pain extending to right flank with a characteristics of persistent pain with a 24hrs a day duration, aggravated when eating, and was relieved when eating cold waxapples, but flaired again after 10-20 minutes. However, intermittent fever with chills and sweating was noted 3 days before she came to our ED. She counldn't bear it anymore and visited in our ED on 101/4/10. The malady was associated with RUQ tenderness, flank soreness, positive Murphy's sign, poor appetite, nausea, constipation, and jaundice. Lab test revealed WBC: 11600/uL(neutrophil predominant, band form: 14%), CRP: 76.35, Hgb:14.1, amylase/lipase: 65/79, ALP/r-GT: 237/875, LFT:GOT/GPT:396/543, bilirubin:T/D:6.09/3.81. Abdominal CT was arranged and revealed distension of gallbladder, mild dilation of extra- and intra-hepatic bile duct, and no identifiable obstructive lesion. Radiologist was consulted and a French #7 PTGBD was indwelled on 4/11 with a dark black bile juice drained and cultured. She was on Flumarin for intraabominal infection control. Abdominal sonography was performed and mild pancreatic duct dilation found. MRCP was arranged on 04/17 which showed a focal relative poorly-enhanced lesion at the pancreatic head with dilation of the main pancreatic duct and common bile duct, suspect pancreatic carcinoma or autoimmune pancreatitis. For suspect pancreatic cancer, EUS-guide biopsy was performed, however, the pathological result was negative, and CEA, CA19-9 were checked (within normal range). We removed PTGBD and steroid therapy was used for empiric therapy. However, the jaundice and intermittent epigastraglia got flare up and autoimmune pancreatitis profile was negative, so we discontinued steroid therapy. After discussed with patient, she preferred to recieve operation, therefore hepatobiliary surgeon arranged Whipple operation for her. The pathological report revealed ductal adenocarcinoma, grade II, pT3N1.

Discussion: For patient with jaundice, we may pay more attention for bile duct or pancreatic duct even there was no obvious obstructive lesion found by abdominal sonography or CT. MRCP was more sensitive for obstructive lesion.