中文題目:阻塞性黃疸案例分享:原發性胰臟淋巴癌

英文題目: A Rare cause of Obstructive Jaundice: Primary pancreatic lymphoma

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Case report: An 84-year-old woman with a history of hypertension was admitted because of abdominal pain and jaundice of three weeks' duration. She had lost 7 kg in the past three months and had noted yellow sclera and tea-colored urine. She had no fever, night sweats, or localized abdominal pain. Laboratory studies revealed direct hyperbilirubinemia (total bilirubin, 10.5 mg/dl; direct bilirubin, 9.5 mg/dl), liver enzyme abnormalities (alanine aminotransferase, 155 IU/L; aspartate aminotransferase, 147 IU/L; serum alkaline phosphatase, 565 IU/L), elevated serum lipase (2078 U/L), and normal peripheral-blood leukocyte count (8,200/µl). Computed tomography (CT) of the abdomen revealed a 6-cm circumscribed, homogeneous,bulging mass involving the pancreatic head and uncinate process, with associated mild dilatation of the common bile duct and pancreatic duct but no vessel invasion (Fig. 1, 2). Immunohistochemical staining of tissue obtained by endoscopic ultrasound with fine-needle aspiration revealed round, blue cells, which were CD20(+), bcl-2(-), bcl-6(+), MUM1(-), CD10(-), and Ki-67 index > 90%, a staining pattern characteristic of diffuse large B-cell lymphoma (Fig. 3). No bone marrow involvement was seen on bone marrow biopsy. Further laboratory studies revealed elevated serum lactate dehydrogenase (347 IU/L) and normal values of carcinoembryonic antigen and CA19-9. She received chemotherapy with rituximab, vincristine, and prednisolone for treatment of primary pancreatic lymphoma. A subsequent abdominal CT scan revealed decreased tumor size and resolution of the biliary and pancreatic obstruction (Fig. 4).

Discussion: Primary pancreatic lymphoma (PPL) is rare disease, comprising <2% of extranodal lymphomas and 0.5% of pancreatic tumors.[1] Diffuse large B-cell lymphoma is the most common type of primary non-Hodgkin's lymphoma.[1] The morphologic patterns of PPL in CT scans can be a localized, well-circumscribed tumor or diffuse enlargement with infiltration. As in the case presented here, the tumor can cause the typical double-duct sign of pancreatic adenocarcinoma (Fig. 2, 3). Some CT characteristics that can help in distinguishing PPL from adenocarcinoma are: (1) vascular invasion is less common with PPL;[3] (2) a bulky pancreatic head tumor without significant dilatation of the main pancreatic duct (with a ratio of duct diameter to distal gland width invariably less than 0.5) favors the diagnosis of PPL; and (3) invasive tumor not respecting anatomic boundaries and infiltrating

retroperitoneal or upper abdominal organs and the gastrointestinal tract may be a reliable sign of non-Hodgkin's lymphoma.[3]

PPL has a better prognosis than does adenocarcinoma because chemotherapy generally produces long-term disease regression or remission. Clinical manifestations and imaging methods provide clues to the diagnosis of PPL, but fine-needle aspiration and tissue histology may be required in order to reach an accurate diagnosis in cases with ambiguous imaging findings.

Figure 1

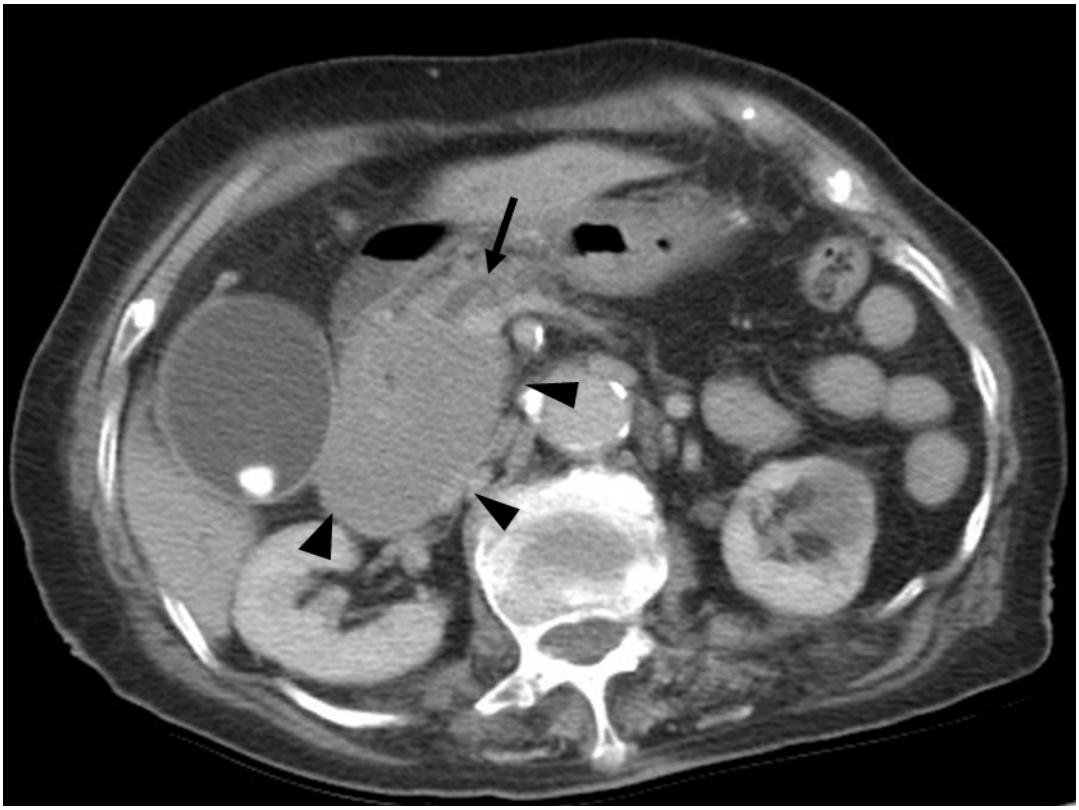
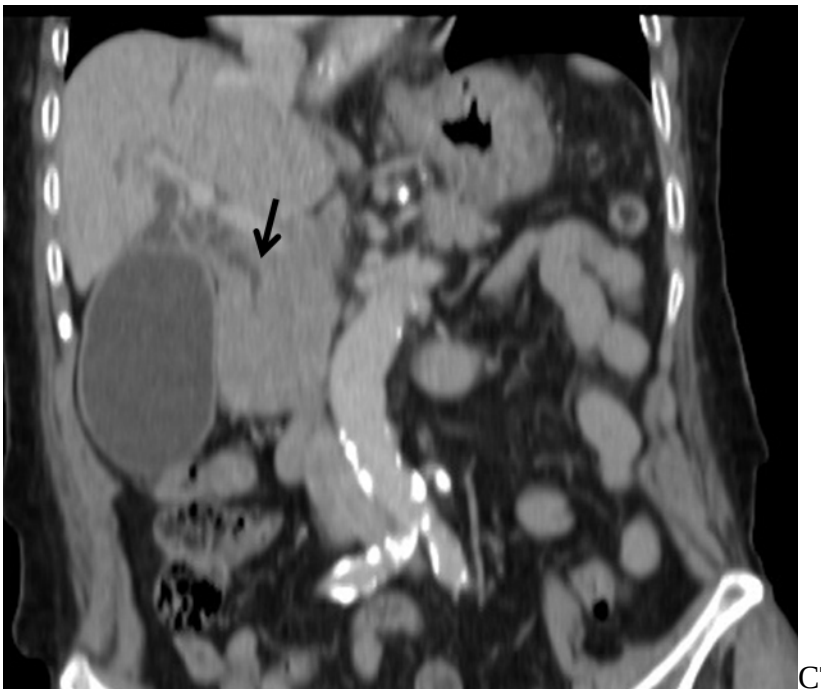


Figure 2



CT

Figure 3

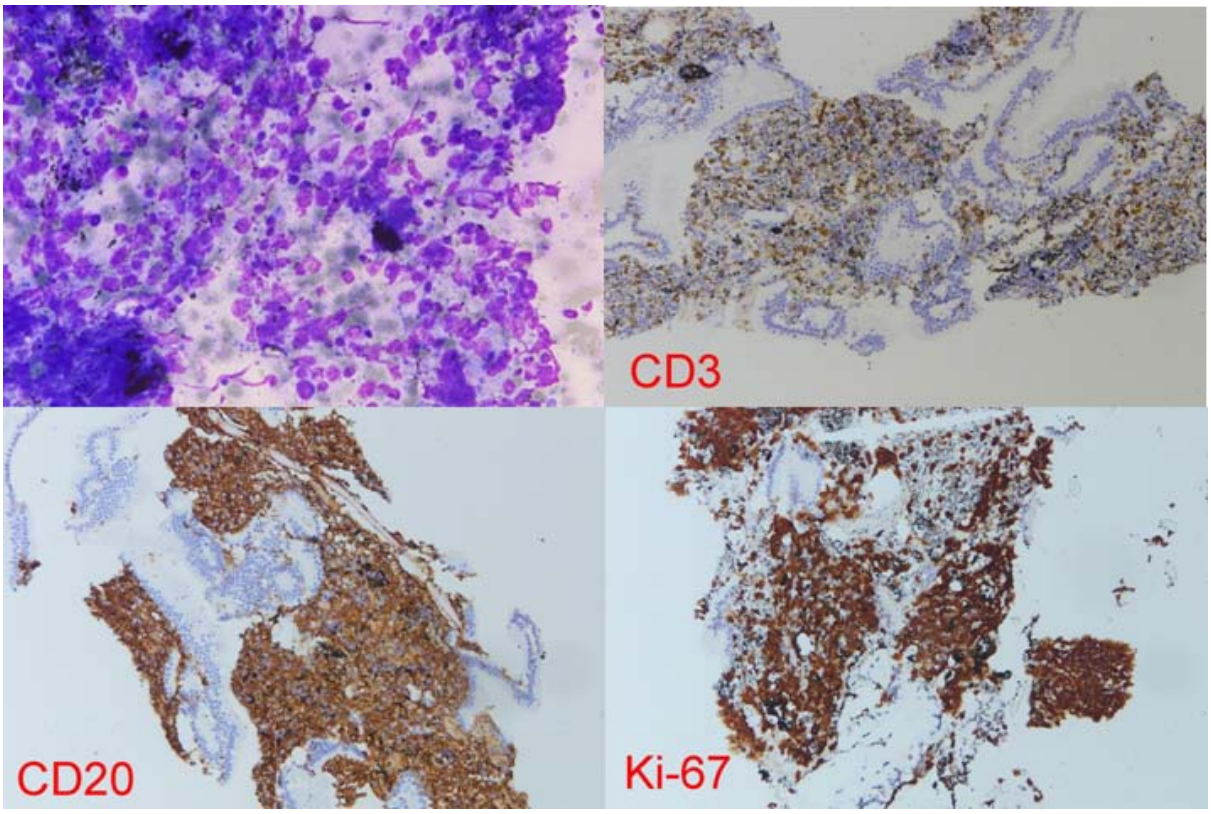


Figure 4

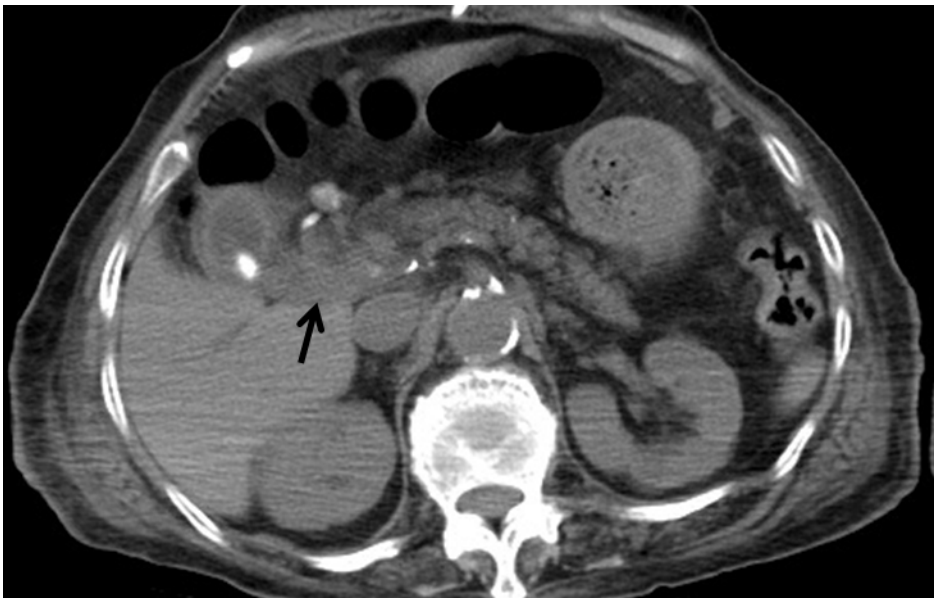


Figure legends

Fig. 1. Enhanced CT scan reveals a well-circumscribed homogeneous tumor (arrowheads) and a dilated pancreatic duct of 3 mm diameter (dashed arrow). No invading vessels near the tumor are present.

Fig. 2. CT scan in sagittal view reveals a tumor, distended gallbladder, and dilated common bile duct (dashed arrow).

Fig. 3. (A) Cytology reveals abnormal uniform, large blue cells with lymphogranular bodies.

(B) CD-3 staining is reactive. (C) CD-20 staining is strongly positive. (D) Ki-67 is strongly positive.

Fig. 4. After rituximab-based chemotherapy, the tumor size has decreased to 3 cm (dashed arrow).

References

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