Pancreatic tuberculosis with common bile duct and pancreatic duct dilatation

Fig. 1 Radial endoscopic ultrasound: hypoechoic mass lesion in the head of pancreas.

Fig. 2 Endoscopic ultrasound: lesion obstructing the common bile duct (CBD) as well as the pancreatic duct (PD).

A 40-year-old woman with no comorbidities presented with history of abdominal pain of 3 months' duration and progressively increasing cholestatic jaundice of 2 months' duration. There was profound loss of weight and appetite. Clinical examination revealed deep icterus and a palpable gallbladder. Laboratory investigation revealed conjugated hyperbilirubinemia (total bilirubin: 16.2 mg/dL with conjugated fraction of 12.8 mg/dL) and markedly elevated serum alkaline phosphatase

Fig. 3 Endoscopic ultrasound: lesion infiltrating the portal vein (PV). CBD, common bile duct.

Fig. 4 Endoscopic ultrasound-guided fine needle aspiration from the mass in the head of pancreas.

(580 IU/L; normal < 126 IU/L). Chest radiograph was normal. Ultrasound examination of the abdomen showed a distended gallbladder with no calculi, and both the common bile duct (CBD) and the pancreatic duct were dilated. The lower end of the CBD was obstructed by a hypoechoic mass lesion in the head of pancreas. Side-viewing endoscopy showed normal papilla. Radial endoscopic ultrasound (EUS) examination revealed a 3.6 cm × 2.4 cm hypoechoic mass lesion in the head of

pancreas (● Fig. 1). This lesion was obstructing the CBD and the pancreatic duct (● Fig. 2) and also infiltrating the portal vein (● Fig. 3). No significant peripancreatic or celiac axis lymphadenopathy was noted. EUS-guided fine needle aspiration (EUS-FNA) was done from the mass in the head of pancreas using a linear echoendoscope (● Fig. 4). The cytological analysis of the aspirate revealed epithelioid cell granuloma (● Fig. 5), but no acid-fast bacilli were noted. The patient was started on four-drug antitubercular therapy and within 2 weeks the pruritus subsided. The liver function tests normalized after 3 months of antitubercular therapy and an ultrasound of the abdomen after 3 months of therapy revealed normal pancreas. On EUS of the head of pancreas 4 months later, there was no mass and few echogenic strands were noted. Pancreatic tuberculosis is rare, probably because of the antibacterial effect of pancreatic enzymes [1]. The clinical and radiological findings of pancreatic tuberculosis usually mimic pancreatic malignancy; both conditions tend to occur more commonly in the head and uncinate process, probably due to the rich blood

Fig. 5 Epithelioid cell granuloma (May–Grünwald–Geimsa, magnification $\times 20$). Inset: epithelioid cells (May–Grünwald–Geimsa, magnification $\times 40$).

supply [2]. In spite of these similarities, it has been shown that the CBD and the pancreatic duct are usually normal in patients with pancreatic tuberculosis, even with a centrally located head mass [3]. However, in our case both the ducts were dilated. Percutaneous imaging or EUS-FNA can help in establishing the correct diagnosis and preventing morbid surgery. Because of the rarity of this disease, there are no treatment guidelines but most patients respond well to 6–12 months of anti-tubercular therapy.

Endoscopy_UCTN_Code_CCL_1AF_2AZ_3AD

Competing interests: None

S. S. Rana¹, D. K. Bhasin¹, N. Gupta², K. Singh¹

¹ Department of Gastroenterology, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, India

² Department of Cytology, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, India

References

- 1 Woodfield JC, Windsor JA, Godfrey CC *et al*. Diagnosis and management of isolated pancreatic tuberculosis: recent experience and literature review. *ANZ J Surg* 2004; 74: 368–371
- 2 Teo LLS, Venkatesh SK, Ho KY. Clinic in diagnostic imaging. *Singapore Med J* 2007; 48: 687–692
- 3 De Backer AI, Mortelet KJ, Bomans P *et al*. Tuberculosis of the pancreas: MRI features. *AJR Am J Roentgenol* 2005; 184: 50–54

Bibliography

DOI 10.1055/s-0030-1256417

Endoscopy 2011; 43: E282–E283

© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

Corresponding author

Dr S. S. Rana

Department of Gastroenterology
PGIMER

Chandigarh 160 012

India

Fax: +91-172-2744401

drsurrinderrana@yahoo.co.in