Tubercular lymph nodal mass mimicking pancreatic malignancy with extrahepatic biliary obstruction in a young woman

Fig. 1 Endoscopic ultrasound (EUS) scan performed in a 20-year-old woman showed a mass lesion above the common bile duct. The pancreatic parenchyma and pancreatic duct are normal. The common bile duct (the long, tubular structure present from 6 to 8 o’clock) is compressed by this mass lesion and dilated above it.

Fig. 2 Cytopathology of the fine-needle aspiration (FNA) biopsy showed: a well-formed granulomas (lower left of image); b numerous acid-fast bacilli (red rods, Ziehl–Neelsen stain; magnification × 100).

A 20-year-old woman presented with a complaint of weight loss over the previous 2 months. There was no history of cough, expectoration, abdominal pain or altered bowel habits. She had no significant past history. An abdominal ultrasound scan showed an ill-defined mass lesion causing a biliary obstruction and dilatation of the intrahepatic biliary radicles. An abdominal computed tomography (CT) scan was also performed and this showed a 3×2.9-cm lesion probably arising from the head of the pancreas; however, the type and exact origin could not be determined.

An endoscopic ultrasound (EUS) scan was performed to characterize the lesion and to carry out a fine-needle aspiration (FNA) biopsy. Endoscopic ultrasound (EUS) showed a heterogeneous mass lesion arising from the duodenal bulb. The common bile duct (Fig. 1) was compressed by this lesion; it was dilated proximally to it, and was of normal size below it. The pancreatic duct and parenchyma were normal (Fig. 1). A significant portion of the course of the common bile duct was seen between the mass lesion and the pancreas, hence the lesion arose from the hepatoduodenal region and not from the head of the pancreas. Given the young age of the patient, the possibility of a conglomerate of lymph nodes mimicking a mass-like lesion was borne in mind. The FNA biopsy was taken with a 22G needle, and two passes were made. Cytopathology showed well formed granulomas (Fig. 2a) and the presence of acid-fast bacilli (Fig. 2b). The patient was started on antitubercular treatment and is doing well.

Tuberculosis mimicking malignancy is well known; it may present as a mass lesion in the pancreatic head [1]. Tuberculosis may cause obstructive jaundice by multiple mechanisms including common bile duct compression by the mass lesion of the pancreatic head, lymph nodal compression, biliary stricturing or retroperitoneal lesion causing biliary obstruction [2, 3]. EUS should be used in suspected pancreatobiliary cases as it has excellent resolution and FNA can be performed simultaneously.

Competing interests: None
Narendra S. Choudhary\textsuperscript{1}, Mridula Guleria\textsuperscript{2}, Rajesh Puri\textsuperscript{1}, Randhir Sud\textsuperscript{1}

\textsuperscript{1}Institute of Digestive and Hepatobiliary Sciences, Medanta, The Medicity, Gurgaon, Haryana, India
\textsuperscript{2}Department of Cytopathology, Medanta, The Medicity, Gurgaon, Haryana, India

References


Bibliography

DOI http://dx.doi.org/10.1055/s-0034-1377769
Endoscopy 2015; 47: E53–E54
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author

Rajesh Puri
Institute of Digestive and Hepatobiliary Sciences
Medanta
The Medicity
Sector 38
Gurgaon
Haryana 122001
India
Fax: +91-124-4834111
purirajesh69@gmail.com

Choudhary Narendra S et al. Tubercular lymph nodal mass with extrahepatic biliary obstruction in a young woman... Endoscopy 2015; 47: E53–E54