

Pancreatic tuberculosis with common bile duct and pancreatic duct dilatation

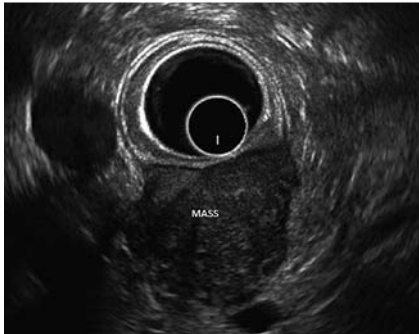


Fig. 1 Radial endoscopic ultrasound: hypoechoic mass lesion in the head of pancreas.

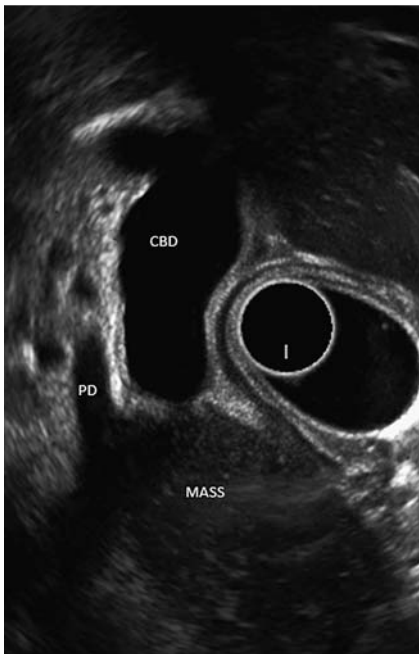


Fig. 2 Endoscopic ultrasound: lesion obstructing the common bile duct (CBD) as well as the pancreatic duct (PD).

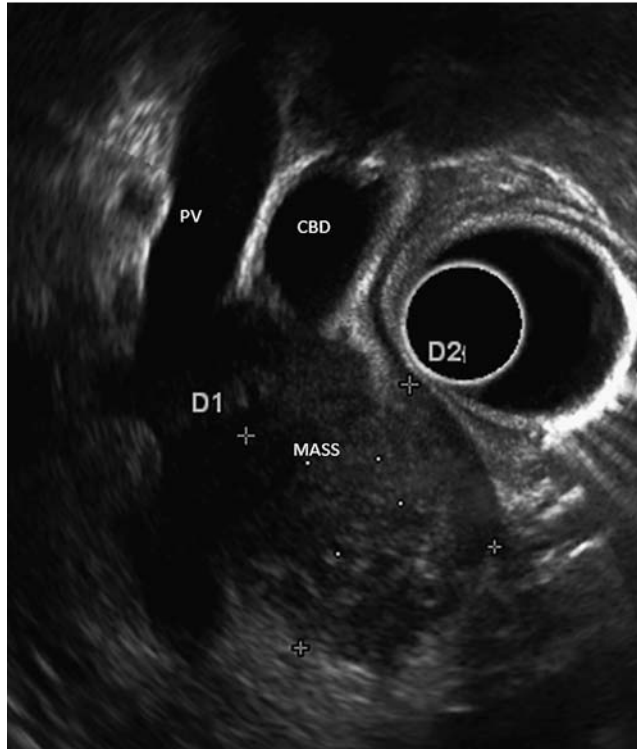


Fig. 3 Endoscopic ultrasound: lesion infiltrating the portal vein (PV). CBD, common bile duct.



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

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

(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

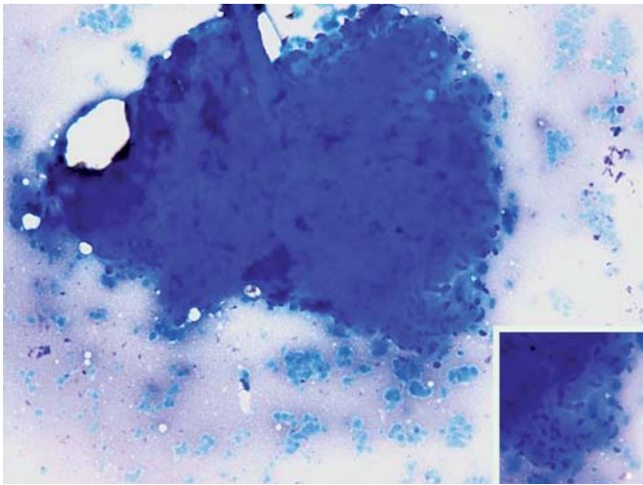


Fig. 5 Epithelioid cell granuloma (May–Grünwald–Geimsa, magnification ×20). Inset: epithelioid cells (May–Grünwald–Geimsa, magnification ×40).

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.

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Competing interests: None

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