A 52-year-old man presented to the emergency department with jaundice, pale stools, and dark urine for 1 week, having lost 15% of his body weight during the previous month. He was a heavy smoker and drinker. He had been diagnosed 4 months previously with a meningeal hemangiopericytoma that had been surgically resected then treated with cranial external radiotherapy. Laboratory evaluation was remarkable for hyperbilirubinemia (9 mg/dL) and cholestasis (alkaline phosphatase [ALP] 1300 IU/L). Magnetic resonance imaging (MRI) revealed a 25-mm pancreatic head mass and upstream dilatation of the bile ducts but a normal main pancreatic duct (Fig. 1). A second 15-mm mass in the uncinate process was also noted.

The patient underwent an endoscopic ultrasound (EUS) using a linear echoendoscope (UCT 10–140 AL5; Olympus), which revealed a slightly heterogeneous, hypoechoic, ill-defined mass in the pancreatic head from which a fine needle aspiration (FNA) was taken with a 25G needle (Wilson Cook; Fig. 2 a). The second smaller lesion was also visualized in the uncinate process close to the superior mesenteric vein (Fig. 2 b).

During the same session, endoscopic retrograde cholangiopancreatography (ERCP) was performed as a tandem procedure and a 7-cm long, 7-Fr plastic biliary prosthesis was placed to allow adequate biliary drainage. Evaluation of the cell block cytology was consistent with hemangiopericytoma (Fig. 3). The patient died 2 weeks later from uncontrolled seizures.

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Competing interests: None

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Fig. 3  Cytology examination of the pancreatic mass showing: a numerous crowded atypical cells with pleomorphic nuclei (hematoxylin and eosin [H&E] stain; magnification × 300); b positive staining for CD34; c positive staining for bcl-2.