An 8-year-old girl presented with abdominal pain and jaundice of 1 month's duration. She had conjugated hyperbilirubinemia and negative hepatitis serology. Computed tomography showed a mass in the head of the pancreas, with foci of calcification and cystic/necrotic areas (Fig. 1). Pancreatoblastoma and Frantz tumor were suspected. The patient underwent a cholecystojejunal anastomosis, and intraoperative biopsy of the pancreatic mass yielded inconclusive results. She was referred for endoscopic ultrasound (EUS) to re-evaluate the pancreatic mass. EUS showed a solid–cystic lesion in the head of the pancreas without vascular involvement (Fig. 2). The main pancreatic duct and common bile duct were slightly dilated. EUS-guided fine-needle aspiration of the pancreatic mass was done with a 22-gauge needle (EchoTip; Cook Medical, Limerick, Ireland) (Fig. 4). Cytopathologic evaluation of cell block material revealed a small cell neoplasm, and immunohistochemical analysis confirmed the diagnosis of peripheral primitive neuroectodermal tumor (PNET) (Fig. 5, Fig. 6).

PNET belongs to a rare group of tumors called the Ewing sarcoma family of tumors [1–3]. Few PNETs arise in solid organs, and pancreatic PNETs are extremely rare [4–8]. Pancreatic PNETs are highly aggressive. Metastasis and recurrence are common, so that the prognosis is very poor. With modern multidisciplinary treatment, long-term survival can be achieved in 70% to 80% of patients with disease that has not metastasized [9].

The correlation of clinical symptoms with imaging, cytopathologic, and immunohistochemical analysis is useful to establish the diagnosis [10,11]. An atypical rosette array of the cells, cytoplasmic neuronal secretory granules and neurofilaments, and pyknotic nuclear granules are important diagnostic criteria [4–8,12]. Most tumors of the Ewing sarcoma family express high levels of a cell surface glycoprotein, CD99 [13,14].

According to a 2014 review article [15], 14 cases of pancreatic PNET have been reported. This is the first case of a pancreatic PNET diagnosed by EUS.

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**Table 1**

<table>
<thead>
<tr>
<th>Protein</th>
<th>Expression</th>
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</thead>
<tbody>
<tr>
<td>CEA</td>
<td>Negative</td>
</tr>
<tr>
<td>D1 CYCLIN</td>
<td>Focal positive</td>
</tr>
<tr>
<td>SYNAPTOPHYSIN</td>
<td>Focal positive</td>
</tr>
<tr>
<td>CHROMOGNORAIN</td>
<td>Negative</td>
</tr>
<tr>
<td>Alpha-fetoprotein</td>
<td>Negative</td>
</tr>
<tr>
<td>Beta-catenin</td>
<td>Negative</td>
</tr>
<tr>
<td>CK7</td>
<td>Negative</td>
</tr>
<tr>
<td>Ki-67</td>
<td>Positive in 30% of neoplastic cells</td>
</tr>
<tr>
<td>Tdt</td>
<td>Negative</td>
</tr>
<tr>
<td>Alpha-antitrypsin</td>
<td>Negative</td>
</tr>
<tr>
<td>VIMENTIN</td>
<td>Negative</td>
</tr>
<tr>
<td>CD99</td>
<td>Positive</td>
</tr>
<tr>
<td>FLY-1</td>
<td>Focal positive</td>
</tr>
</tbody>
</table>

*Fig. 3* Endoscopic ultrasound (stomach view) showing no echogenic signs of portal vein impairment.

*Fig. 4* Endoscopic ultrasound (stomach view) showing endoscopic ultrasound-guided fine-needle aspiration (22-gauge needle) of the solid cystic mass.

*Fig. 5* Immunohistochemical profile suggestive of primitive neuroectodermal tumor: CEA, carcinoembryonic antigen; CK, cytokeratin; Tdt, terminal deoxynucleotidyl transferase; CD, cluster of differentiation.

*Fig. 6* Pancreatic peripheral primitive neuroectodermal tumor. a Cell block section showing clusters of rather uniform neoplastic cells arranged in a lobular pattern (hematoxylin and eosin, original magnification ×10). b Details of the neoplastic cells, showing scant cytoplasm, mild atypia, and a trabecular architecture. c Immunohistochemical reaction showing strong diffuse positivity for CD99.


Bibliography

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