

A CASE OF LYMPHOPLASMACYTIC SCLEROSING PANCREATITIS WITH CONCURRENT INVASIVE PANCREATIC ADENOCARCINOMA

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Objective: This report is intended to underscore a concurrence of two distinct pathologic processes in a single patient with resulting treatment implications counter to current trends in the literature.

Background: Lymphoplasmacytic sclerosing pancreatitis (LPSP), also termed autoimmune pancreatitis, is a rare form of chronic pancreatitis characterized histologically by a diffuse lymphoplasmacytic infiltrate centered around pancreatic ducts accompanied by obliterative phlebitis. Furthermore, it is associated with elevated serum IgG4 levels and has been reported to respond clinically to treatment with steroids. Previous reports by Kamisawa et al and Inoue et al have linked LPSP to occasional cases of pancreatic ductal cancer.

Methods: This is a case report with independent confirmation of pathology and additional immunohistochemistry.

Results: An 80 year old male presented with obstructive jaundice. He was initially managed with percutaneous transhepatic biliary stenting. Imaging revealed an annular stricture in the distal common bile duct without evidence of pancreatic pathology. Due to the concern of malignancy, he underwent a pylorus preserving pancreaticoduodenectomy. Pathology revealed LPSP with classic duct centric mixed infiltrate and venulitis as well as a poorly differentiated infiltrating adenocarcinoma with extensive nerve invasion. PanIN-3 was also present in the resection specimen. Sixteen lymph nodes were negative for tumor as were all margins for a final pathologic staging of T1N0M0. Immunohistochemical stain of the specimen was positive for IgG4. He was discharged home on postoperative day 6 after an uneventful hospital course. At his routine follow-up visit, he was well and, with consideration of his age, declined adjuvant chemoradiotherapy.

Conclusions: LPSP often mimics pancreatic adenocarcinoma in its presentation. Currently, a definitive diagnosis is made only after surgical resection or in rare instances from tissue returned at EUS/FNA or biopsy. There is a trend, however, towards trying to establish a definitive diagnosis without surgical intervention through radiographic criteria, serology, and responsiveness to steroids. The diagnosis of LPSP does not preclude the possibility of invasive adenocarcinoma. This case should be viewed as a cautionary tale about the possible pitfalls of conservative management of malignant appearing pancreaticobiliary pathology.