Isolated pancreatic tuberculosis mimicking inoperable pancreatic cancer: A diagnostic challenge resolved by endoscopic ultrasound-guided fine-needle aspiration

Adrien Sportes MD1, Raimi Kpossou MD1, Stephanie Bernardin MD2

CASE PRESENTATION
In December 2010, a 52-year-old man was admitted to hospital for febrile cholestatic jaundice. The patient was of Algerian origin and had immigrated to Alsace (France) two years previously. He was a construction worker with no medical or surgical history, nor was there history of contact with tuberculosis. The clinical history began one month previously, with diffuse abdominal pain, weight loss and jaundice.

Physical examination on admission revealed a temperature of 38.5°C, epigastric abdominal pain associated with scleral jaundice and no lymphadenopathy. The remainder of the physical examination was unremarkable.

The patient's initial laboratory analysis revealed a leukocyte count of 7.07 × 10^9/L, a hemoglobin level of 97 g/L and a platelet count of 259 × 10^9/L. Cholestasis was demonstrated by increased serum levels of gamma-glutamyltranspeptidase (336 U/L; normal range 41 U/L to 117 U/L), alkaline phosphatase (177 U/L; normal range 41 U/L to 117 U/L) and total bilirubin (30 μmol/L; normal range 1.7 μmol/L to 21 μmol/L), with a direct bilirubin level of 20 μmol/L (normal range 1 μmol/L to 10 μmol/L) and alanine aminotransferase level of 120 U/L (normal range 10 U/L to 49 U/L). Acute phase reactants increased, with a C-reactive protein level of 63 mg/L (normal <4 mg/L). Tests for HIV 1 and 2, and hepatitis B and C were negative.

Computed tomography (CT) showed a heterogeneous mass in the head of the pancreas 3.5 cm × 4.5 cm in size, causing a compression of the bile duct, with dilation of the intra- and extrahepatic bile ducts. The tumour was in contact with the superior mesenteric vein and artery. In addition, many peripancreatic lymph nodes were present (Figure 1).

Magnetic resonance cholangiopancreatography was performed and revealed dilation of the intra- and extrahepatic bile ducts upstream of a cephalic pancreatic mass, with dilation of the duct of Wirsung (Figure 2).

The initial differential diagnosis was cholangitis secondary to a malignant tumour of the pancreatic head without knowledge of the histological type.

Given the septic context and the presence of a locally advanced tumour (invasion of the superior mesenteric artery and vein), it was decided to perform endoscopic ultrasound (EUS)-guided fine-needle aspiration (FNA) of the mass of the head of the pancreas, along with placement of a metal biliary stent. EUS revealed a large tumour in the head region of the pancreas compressing the bile duct, and many peripancreatic lymph nodes and some ascites (Figure 3).

Cytology demonstrated granuloma with caseous necrosis and the presence of an aspect of diffuse necrosis, the absence of tumour cells and tuberculosis bacterium. The assessment was completed using a CT scan-guided transmural biopsy of the peripancreatic lymphadenopathy. Pathological examination revealed caseous necrosis with the presence of acid-fast bacillus; Ziehl-Neelsen stain staining was positive. Additionally, bacteriologically samples returned positive for Mycobacterium tuberculosis with polymerase chain reaction DNA.

The final diagnosis was isolated pancreatic tuberculosis complicated by cholangitis. Antituberculous therapy was initiated, leading to clinical, biological and radiological improvement (Figure 5). The metal biliary stent was replaced with a plastic stent. It was replaced once again before its final removal in September 2011.

DISCUSSION
Isolated pancreatic tuberculosis is rare (1), even in endemic countries. In France, two cases have been reported in the literature. Pancreatic tuberculosis is most often associated with miliary tuberculosis (2,3) or immunosuppression by HIV. Our patient had no miliary tuberculosis or HIV infection, or other causes of immunosuppression.

The pathogenesis in this context may be due to hematogenous extension (4). Invasion of the pancreas by tubercle bacilli disseminated through penetration of the organ by adjacent caseating abdominal lymph nodes (5).

In most cases, pancreatic and peripancreatic tuberculosis evolves through multiorgan damage; however, primitive forms exist and are isolated in 25% of cases (6).

In the present case, the initial diagnosis was a locally advanced pancreatic tumour and EUS-guided FNA helped to rectify the diagnosis.

The clinical significance of this observation is based, in part, on the rarity of pancreatic tuberculosis in France and on the significant value of EUS-guided FNA in the diagnosis. This is rare enough (7) to...
be reported because the diagnosis is most often made intraoperatively during exploratory laparotomy (8).

A retrospective study involving patients with pancreatic tuberculosis (9) reported the sensitivity of EUS-FNA to be 76%, without major complications. These data are comparable with those found in pancreatic cancers (10). Therefore, surgical management is not indicated as first-line management.

In our patient, the presence of jaundice was indicative of pancreatic tuberculosis. This mode of revelation is rare, although similar cases are found in the literature (11,12).

The usual clinical manifestations are chronic abdominal pain, pancreatic mass suggestive of cancer (13-15), obstructive jaundice (13), gastrointestinal bleeding (16), acute or chronic pancreatitis (17), or pancreatic abscess (18). However, signs of tuberculous infection may be absent (19).

This disease is usually found in patients in highly specific situations (eg, residents in endemic areas, immunocompromised individuals). A diagnosis of pancreatic tuberculosis should be considered in a pancreatic mass. This diagnosis is a challenge due to its rarity in patients in endemic areas, immunocompromised individuals. A diagnosis of pancreatic tuberculosis should be considered in a pancreatic mass. This diagnosis is a challenge due to its rarity in patients in endemic areas, immunocompromised individuals. A diagnosis of pancreatic tuberculosis should be considered in a pancreatic mass. This diagnosis is a challenge due to its rarity in patients in endemic areas, immunocompromised individuals. A diagnosis of pancreatic tuberculosis should be considered in a pancreatic mass. This diagnosis is a challenge due to its rarity in patients in endemic areas, immunocompromised individuals. A diagnosis of pancreatic tuberculosis should be considered in a pancreatic mass. 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