A diffusely enlarged pancreas: the (un)usual suspect

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CASE REPORT

An 81-year-old female presented with obstructive jaundice and a non-specific clinical picture of nausea and appetite loss. Labs demonstrated a conjugated hyperbilirubinemia (7.7 mg/dL), increased aspartate aminotransferase and alanine aminotransferase (10x ULN and 8x ULN, respectively), increased lactate dehydrogenase (10x ULN) and serum lipase (3x ULN). CA 19.9 was 342 U/mL (ref. value < 37 U/mL). There was no evidence of peripheral lymphadenopathy or hepatosplenomegaly. Imaging (Fig. 1 A and B) revealed a marked homogeneous enlargement...
of the pancreas (without any well-defined mass), dilation of the extra and intra-hepatic bile ducts and ascites. Endoscopic ultrasound (Fig. 1 C and D) identified an enlarged homogeneous hypoechoic pancreas, without any well-defined lesion, no dilation of the main pancreatic duct, and no peripancreatic or celiac enlarged lymph nodes. A fine-needle biopsy was performed yielding, on cytological examination and cell-block technique (Fig. 2 A and B), numerous medium/large sized atypical lymphoid cells that displayed a B-cell lineage immunophenotype (Fig. 2 A-F). Even though further characterization (by flow cytometric immunophenotyping) could not be obtained, a final diagnosis of primary pancreatic lymphoma (PPL) was assumed.

**DISCUSSION**

Primary pancreatic lymphoma is a remarkably rare tumor of the pancreas, representing approximately 0.5% of all pancreatic neoplasms and < 2% of all lymphomas (1,2). A correct diagnosis is crucial because therapeutic management differs from other pancreatic malignancies (pancreatic ductal adenocarcinoma, neuroendocrine tumor and metastases) (2,3). Two morphologic patterns of PPL are recognized: a focal form (occurring in the pancreatic head in 80% of cases) and a rarer diffuse/infiltrative pattern, as depicted herein, emulating an acute/autoimmune pancreatitis (1).

![Fig. 2. Cytological examination (A: Giemsa staining, 20x) and cell-block technique (B: hematoxylin & eosin staining, 40x) showed the presence of numerous medium/large sized atypical lymphoid cells. Those cells were positive for CD20 (C), CD10 (D), BCL2 (E) and BCL6 (F) and negative for CD3, CD5, CD21, CD23 and cyclin D1.](image-url)
REFERENCES

