

Letters to the Editor

Differential diagnosis between autoimmune pancreatitis and pancreatic cancer: review of a case

Key words: Autoimmune pancreatitis. Immunoglobulin G4 (IgG4)-associated systemic disease. Pancreatic tumor.

Dear Editor,

Autoimmune pancreatitis (AIP) is a rare, chronic fibroinflammatory pancreatic disease, considered to be part of immunoglobulin G4 (IgG4)-associated systemic disease (1). AIP and pancreatic cancer may present as a focal mass, then, differential diagnosis between both entities is important because it can avoid unnecessary pancreatic resections (2). Currently, there are no uniformly accepted diagnostic criteria, so the diagnosis is based on several criteria: clinical, radiological and histological features proposed by several researchers in Japan and Korea and at Mayo Clinic (1,3).

Case report

We present the case of a 39-year-old male who was referred for epigastric pain and cholestatic signs for a week. He denied any pathological history about him or his family. In the physical examination, the patient showed only cutaneous and mucosal jaundice.

Investigation revealed: gammaglutamyl transpeptidase (GGT): 2095 U/L, alkaline phosphatase (AP): 226 U/L, total bilirubin (TB), 2.1 mg/dL (direct bilirubin: 1.9 mg/dL), ALS: 208 U/L, ALT: 528 U/L, amylase: 140 U/L. Lipase, leukocytes, CRP was

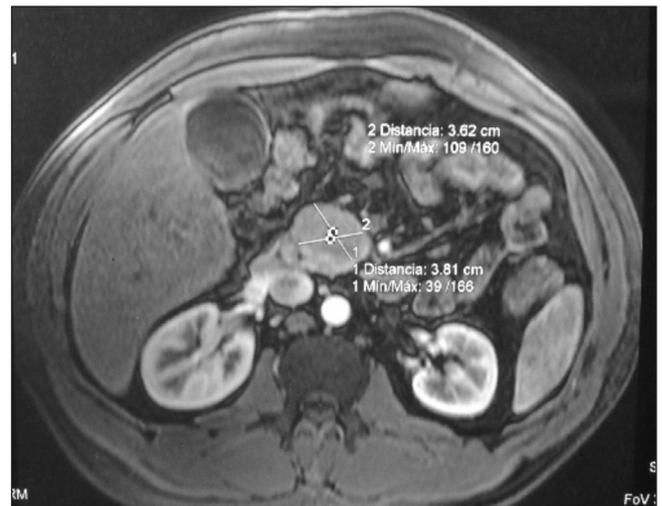


Fig. 1.

normal. Abdominal ultrasound shows homogeneous and diffuse increase of the pancreas size, with free fluid around vesicular and in pelvis, suggestive of acute pancreatitis. We performed nuclear magnetic colangiorensonance (CRMN) (Fig. 1) to search for chole-docholithiasis associated and we observed a moderate dilatation of the intra and extrahepatic bile duct and Wirsung duct dilatation without lithiasis. In the pancreatic head, there was a mass of 3.8 x objective 3.6 cm displacing the superior mesenteric artery and vein. A computed tomography (CT) showed similar findings, so we required an endoscopic ultrasonoguided fine-needle aspiration (USE-PAAF), without obtaining a valid sample.

Throughout the hospital admission, the patient was asymptomatic but his cholestasis continued to rise: TB: 15 mg/dL, GGT:1364 U/L, AP: 230 U/L, with normal tumor markers.

In order to differential diagnosis between inflammatory pancreatic mass and cancer, we demanded the following test: IgG4 levels and autoantibodies. We found out risen levels of IgG4 (366 U/L) and I and II anti-carbonic anhidrase antibodies were

positive. Based on the diagnostic criteria recommended by Japan Pancreas Society and Mayo Clinic, was found out high probability of AIP, so steroid therapy was prescribed. In the first two weeks of treatment, the patient showed improvement in laboratory test and the focal mass disappeared after 8 months of treatment. Nowadays, he is asymptomatic with minimal doses of corticosteroids.

Discussion

The differential diagnosis between AIP and pancreas cancer is based on several criteria like typical image features, risen serum IgG4 levels, other organs involved, typical histological features and resolution or marked improvement of pancreatic/extra-pancreatic manifestation with steroid therapy. It is often not possible to obtain a representative pancreatic tissue sample; therefore, it is necessary to consider the importance of the other criteria (1-3).

From our experience, these clinical and radiological criteria developed by Japan Society and the Mayo Clinic have been enough to make a differential diagnosis. It was not necessary to get pancreatic tissue and undergo the patient to surgery (1,3).

There are no uniformly accepted diagnostic criteria for AIP, due to the lack of studies because of the low incidence of this dis-

ease. However, the communication in cases like these could be interesting to link these criteria (4,5).

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