

Cholelithiasis and complicated chronic pancreatitis mimicking malignancy

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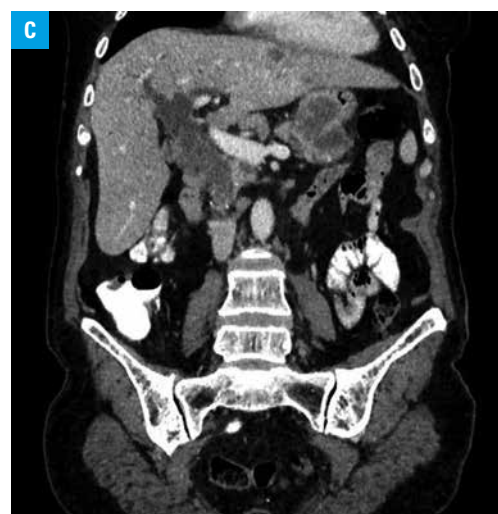
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A 68-year-old female patient was admitted to our department for the diagnosis of hepatic focal lesions discovered on conventional ultrasound. The ultrasound was performed for acute exacerbation of recurrent abdominal pain, which the patient had been experiencing for the previous 10 years.

On admission, the patient complained of generalized weakness and a weight loss of 10 kg over the previous 6 months. Laboratory blood tests showed elevated levels of inflammatory markers, cholestasis parameters, and tumor markers (CEA-1114 U/l, CA 19-9-224 ng/ml). During the

hospitalization, contrast-enhanced computed tomography (CECT) of the abdomen revealed innumerable hepatic focal lesions, intraluminal malignant lesions in the common bile duct (CBD), chronic pancreatitis with pancreatic body fluid collection, and enlarged local lymph nodes around the portal vein, around the common hepatic artery, and in the retroperitoneal space (FIGURE 1A–C). Following the discussion of the CECT images during surgical and radiological case conferences, a differential diagnosis of metastatic cholangiocarcinoma versus metastatic intraductal papillary mucinous neoplasm type I was made. Endoscopic ultrasonography (EUS) and endoscopic retrograde cholangiopancreatography (ERCP) were recommended to establish a definite diagnosis.

During EUS, a central walled-off pancreatic necrosis (WOPN) was recognized, for which transmural drainage was performed (FIGURE 1D). After 8 days of active drainage, nasal drain was removed and ERCP was performed to visualize a dilated CBD with numerous gallstones (FIGURE 1E), partial disruption, and stricture of the main pancreatic



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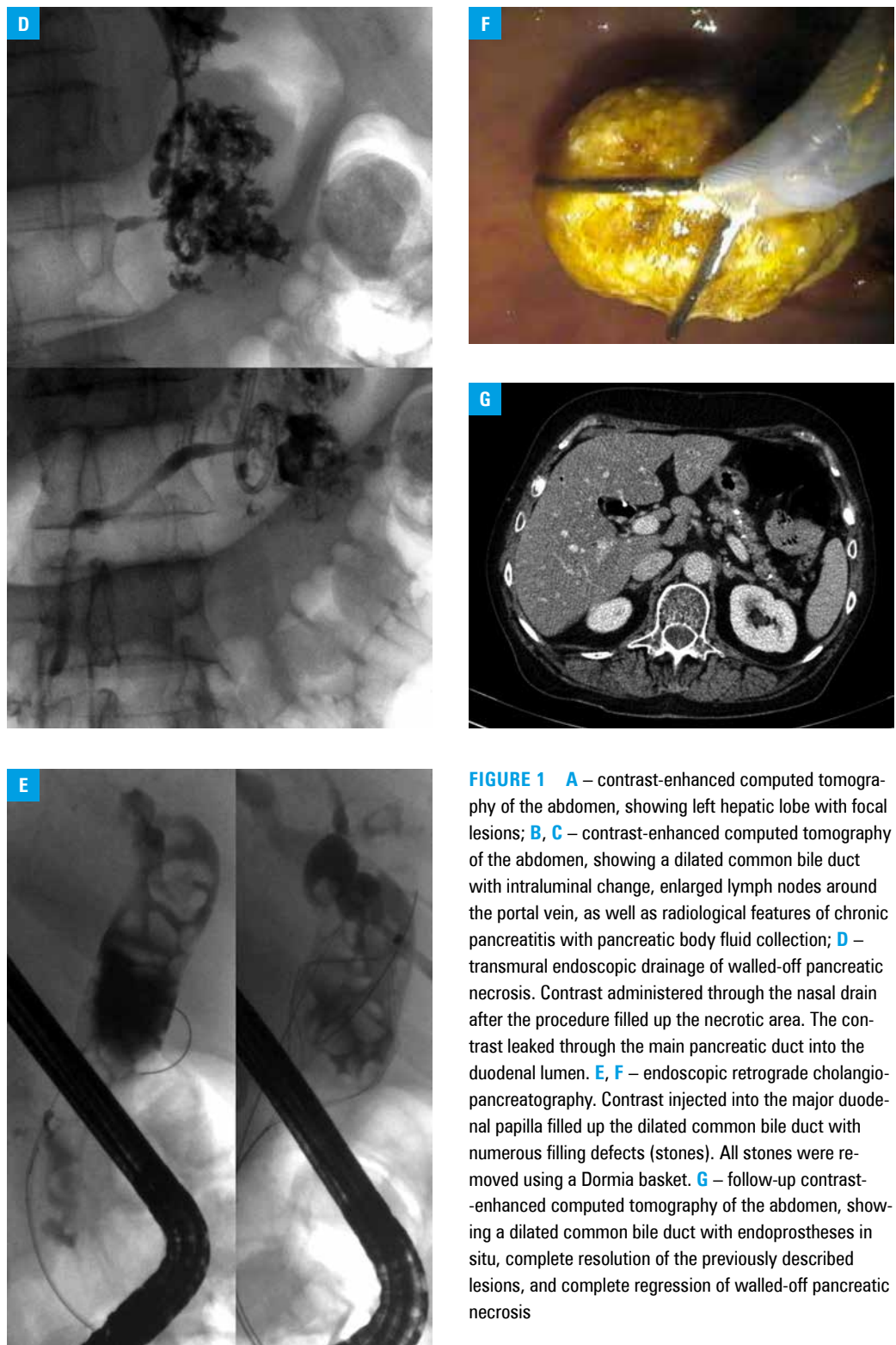


FIGURE 1 **A** – contrast-enhanced computed tomography of the abdomen, showing left hepatic lobe with focal lesions; **B, C** – contrast-enhanced computed tomography of the abdomen, showing a dilated common bile duct with intraluminal change, enlarged lymph nodes around the portal vein, as well as radiological features of chronic pancreatitis with pancreatic body fluid collection; **D** – transmural endoscopic drainage of walled-off pancreatic necrosis. Contrast administered through the nasal drain after the procedure filled up the necrotic area. The contrast leaked through the main pancreatic duct into the duodenal lumen. **E, F** – endoscopic retrograde cholangiopancreatography. Contrast injected into the major duodenal papilla filled up the dilated common bile duct with numerous filling defects (stones). All stones were removed using a Dormia basket. **G** – follow-up contrast-enhanced computed tomography of the abdomen, showing a dilated common bile duct with endoprosthesis in situ, complete resolution of the previously described lesions, and complete regression of walled-off pancreatic necrosis

duct at the isthmus and body. CBD stones were extracted using a Dormia basket (**FIGURE 1F**); 2 endoprosthesis were inserted into the CBD. After brush cytology samples were taken from the strictures of the main pancreatic duct, endoprosthesis was led into the pancreatic duct. Brush cytology samples from the main pancreatic duct, as well as biopsy samples obtained from the liver and enlarged lymph nodes, revealed no features suggestive of malignancy on a subsequent histopathological examination.

A CECT performed after 6 months of follow-up showed regression of the WOPN and other intra-abdominal lesions revealed by the first CECT (**FIGURE 1G**). However, 2 months later, spontaneous dislocation of the transpapillary pancreatic stent was found on ERCP, necessitating the exchange of biliary stents.

The patient has been observed for 1.5 year and is currently undergoing biliary endotherapy for cholelithiasis; her general condition has improved, with weight gain and restoration of full physical activity.

We described a case of a female patient whose symptoms, laboratory blood test results, and abdominal CECT strongly suggested cholangiocarcinoma with liver metastasis or metastatic intra-ductal papillary mucinous neoplasm type I, yet she was found to have WOPN with cholelithiasis on endoscopic examinations. This presentation can be explained by cholelithiasis and choledocholithiasis, causing recurrent acute pancreatitis¹ evolving into the chronic pancreatitis² and complicated by central pancreatic necrosis. Hepatic focal lesions may be attributed to abscess formation, complicating the cholelithiasis.

REFERENCES

- 1 Testoni PA, Mariani A, Curioni S, et al. MRCP-secretin test-guided management of idiopathic recurrent pancreatitis: long-term outcomes. *Gastrointest Endosc.* 2008; 67: 1028-1034.
- 2 Bertilsson S, Swärd P, Kalaitzakis E. Factors that affect disease progression after first attack of acute pancreatitis. *Clin Gastroenterol Hepatol.* 2015; 13: 1662-1669.