Question 18 – November 28

A 48 year old male was found to have a mass in the head of the pancreas and biliary obstruction on a CT done for abdominal discomfort for the last 3 months and an elevated bilirubin found on labs at PCP. He has a history of insulin-dependent diabetes, hypertension and Hashimoto's thyroiditis well controlled on oral levothyroxine. EUS revealed an ill-defined hypoechoic area in the head of the pancreas. FNA showed only inflammatory cells. ERCP done at the same time showed an irregular CBD with at least two separate strictures. Brushing and biopsies of the strictures did not reveal malignant cells. A plastic stent was placed. The pancreatic duct was not dilated.

What is the next best step in management of this patient?

A. Repeat EUS with FNA
B. Percutaneous FNA by IR
C. Serum CA19-9 and IgG4
D. MRCP and MR pancreas
E. Liver biopsy

Answer: C

Pancreatic mass, multiple biliary strictures, other autoimmune conditions with a non-diagnostic FNA/brushings and biopsies are suggestive of autoimmune pancreatitis or an IgG4-associated syndrome. HISORt criteria were established to assist in the diagnosis. If there were adequate lymphocytes on the FNA sample, an IgG4 staining can be performed which would help with the diagnosis (Histology). Imaging characteristics are either a sausage shaped pancreas or pancreatic mass. Serology (elevated IgG4 levels more than 2 x upper limit of normal) can be easily checked on this patient and that would be the next best step. Other organ involvement as in this patient with other autoimmune diseases and biliary strictures. If all of the criteria are indeterminate, response to steroid therapy using Prednisone 40 mg per day for 4 weeks and re-imaging to see a radiographic response is used as a last resort.

Reference:

Chari ST et al. Diagnosis of autoimmune pancreatitis: the Mayo Clinic experience. Clin Gastroenterol Hepatol. 2006 Aug; 4(8):1010-6