Inflammatory pseudotumor of the pancreas Head in children

Inflammatory pseudotumors are rare solid benign lesions of unknown etiology (1). They can occur in many parts of the body but mainly the lungs. These lesions have also been termed inflammatory myofibroblastic tumors, post inflammatory tumors, and plasma cell granulomas. Treatment is usually in the form of surgical resection. These unusual lesions with an excellent prognosis may exhibit, atypical radiologic features and nuclear atypia, making the diagnosis difficult with malignancy. We report our success in treatment of pseudotumor inflammatory (IPT) pancreatic head mass without surgery.

Case report

A previously healthy boy presented at 10 years of age with a 2-week history of painless jaundice. He complained of abdominal pain and had clay-coloured stool, dark urine, and itching. On physical examination, he was icteric, and his abdomen was soft, without a palpable mass.

Initial laboratory studies were notable for a total bilirubin of 108 mg/dL, conjugated bilirubin of 66 mg/dL, alkaline phosphatase of 1189 U/L, serum amylase of 96, and a negative hepatitis panel. Abdominal ultrasonography (US) and computed tomography (CT) scan showed a spherical 3.5 cm diameter focal mass within the head of the pancreas, intrahepatic and extra hepatic ductal dilatation and mild pancreatic ductal dilatation without malignancy signs (Figure 1, 2).

Figure 1 : Abdominal ultrasonography: A spherical solid mass in the head of the pancreas.

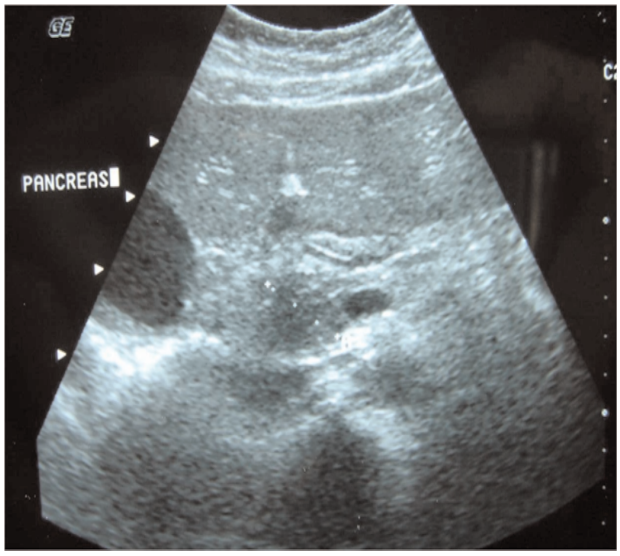
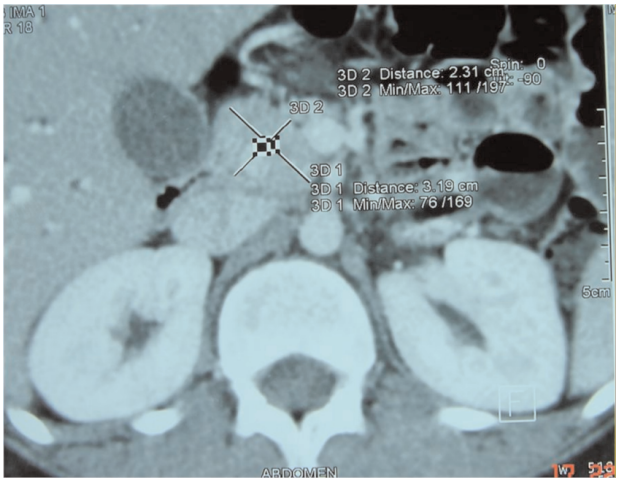


Figure 2 : Abdominal Computed tomography: Mass of the head of the pancreas 2.58 x 3 x 4.18 cm. There is some enhancement and a mixture of hyper-and hypodense areas



A CT scan guided fine needle aspiration was performed (Figure 3). Histologic examination confirmed the diagnosis of IPT of the pancreas: inflammatory cell infiltrate composed mainly of lymphoid and plasma cells with scattered eosinophils. There was no evidence of malignancy (Figure 4).

Figure 3 : A CT scan guided fine needle aspiration.

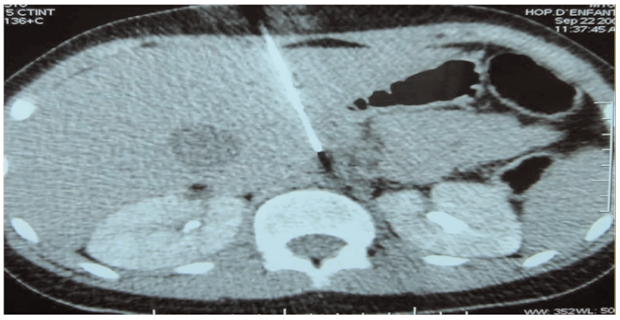
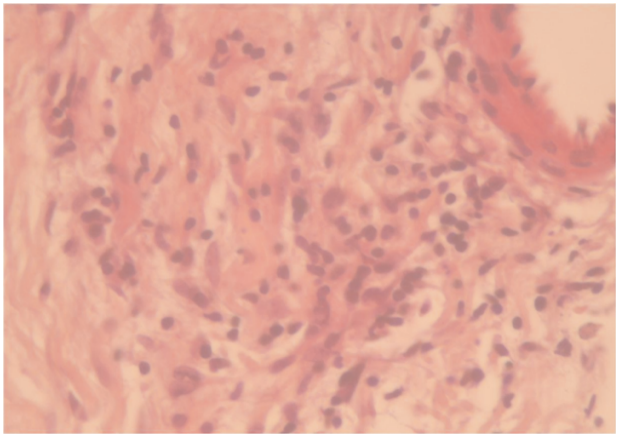
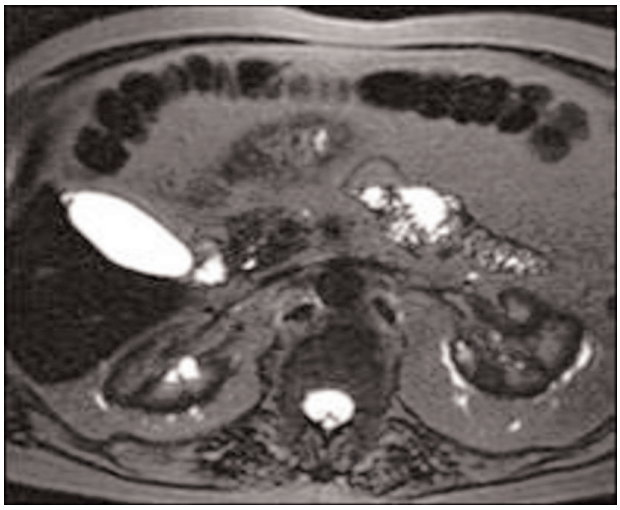


Figure 4 : Histologic examination: Inflammatory cell infiltrate composed mainly of lymphoid and plasma cells with scattered eosinophils. There was no evidence of malignancy.



He was commenced on high-dose prednisolone. The dose of prednisolone used was 2 mg/Kg/day for 4 weeks. For the next 8 weeks, the dose was gradually tapered. Evolution was uneventful with regression of jaundice and itching, liver function tests including serum bilirubin and haematological investigations were normal.
Follow-up at 2 months by (US) and magnetic resonance cholangiopancreatography showed the total regression of the mass and intrahepatic and extra hepatic ductal dilatation (figure 5). He was followed up with serial US, and he remains well and disease free 2 years after medical treatment.

Figure 5 : Magnetic resonance cholangiopancreatography after 2 months of treatment: Total regression of the mass.



Conclusion
Unlike adults with a mass in the head of the pancreas, histologic conformation should be obtained before radical surgery in children. It has not been established whether steroid administration accelerates resolution of IPT, but this case would suggest that symptomatic patients with a secure diagnosis of IPT can benefit with steroid administration, and avoids surgery with its associated morbidity.

References

1- Scott L, Blair G, Taylor G, Dimmick J, Fraser G. Inflammatory pseudotumors in children. J Pediatr Surg 1988; 23:755-8.

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Léiomyomatose intra vasculaire utérine

La léiomyomatose intra vasculaire (LIV) est une tumeur bénigne rare de l'utérus. Elle survient en général au cours d'une pathologie fibromateuse qu'elle peut parfois révéler par les complications liées à sa prolifération et sa migration. Cette tumeur, pourtant bénigne, a un haut potentiel de développement intra vasculaire et nécessite une prise en charge spécifique et une connaissance approfondie de cette pathologie pour éviter une récidive.
Nous rapportons une observation de LIV limitée à la sphère gynécologique.

Observation
Madame L, âgée de 33 ans, nulligeste, cycle menstruel régulier, sans antécédents particuliers, a été prise en charge dans le service pour une volumineuse masse abdominopelvienne d'apparition récente associée à des dysménorrhées avec douleur pelvienne sans ménorragies ou métrorragies, avec notion de dysurie et constipation. L'examen clinique retrouvait une énorme masse abdominopelvienne, bien limitée, ferme, indolore et atteignant l'ombilic.
Le col était macroscopiquement sain. L'échographie mettait en évidence un utérus de taille et d'échostructure homogène, ligne de vacuité fine et en place avec un petit fibrome isthmique surmonté par une masse pelvienne hétérogène, d'échostructure tissulaire, mesurant 165/120 mm et de siège latéro et rétro utérine droite. Les ovaires non vus, ce qui rendait le diagnostic difficile (figure 1, 2). Le marqueur tumoral CA125 était négatif.

Figure 1 : Image échographique montrant l'utérus de taille normale avec la masse en latéro et rétro utérin