A Rare Case of Recurrent Pancreatitis

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Introduction:

- Primary Intestinal Natural Killer/T-cell Lymphoma (NKTCL):
  - Rare and aggressive form of Non-Hodgkin's Lymphoma
  - Most often found in the upper aerodigestive tract

Case Description:

- 45-year-old female with acute epigastric pain and weight loss
- PMHx/PSHx: Stage IB cervical cancer s/p total hysterectomy, BSO and pelvic radiation in 2019
- SH: No EtOH or drug use. Former smoker, quit 15 years ago. No medication changes
- Initial Labs:

Amylase	Lipase	Triglycerides	IgG	Total Bili
905	2383	192	971	0.8

Timeline:

1/12/24	1st Admission for acute pancreatitis • CA 19-9: 93 • CT Abdomen and Pelvis: Prominent pancreatic duct in body and proximal tail without discrete mass or stone • MRCP: Pancreatic duct dilatation with gradual tapering without obvious mass (Fig 1)
2/14/24	Routine PET Scan for monitoring post cervical cancer • Increased FDG uptake in the pancreatic head, neck and proximal body (Fig 2)
2/20/24	2nd Admission for recurrent acute pancreatitis. Discharged with supportive care
2/25/24	3rd Admission for recurrent acute pancreatitis • CT Abdomen and Pelvis: Interval increase in size of the pancreatic head with cystic changes • MRCP: Interval increase in size of pancreatic head, neck and body with several hypo-enhancing foci. Dilated CBD and intrahepatic biliary ducts (Fig 3)
3/18/24	• EUS demonstrated a bulky pancreas - Cytology: Lymphocytic infiltrate of T cell predominance • Development of direct hyperbilirubinemia leading to ERCP with distal CBD stricture with placement of plastic CBD stent. Brushings negative for malignancy (Fig 4) • Started on empiric oral corticosteroids for presumptive autoimmune pancreatitis
3/25/24	• IR Guided Biopsy confirming EBV positive extranodal NKTCL • Final immunostaining from EUS finally returns also consistent with EBV positive T cell proliferation
4/2024	PET Scan: No evidence of involvement of other distal sites MRI Brian, Orbit and Neck: Normal
4/20/24	M-SMILE chemotherapy with plan for consolidative radiation and autologous transplant initiated
4/24/24	Resolution of CBD stricture and removal of existing stent

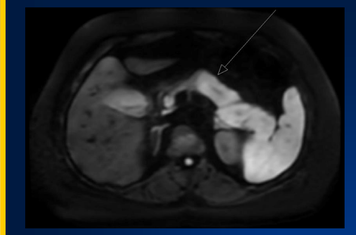

Fig.1 MRCP : Non visualized PD in the region of transition in the pancreatic neck

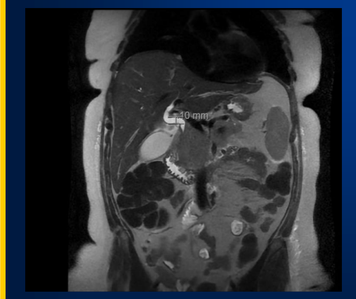

Fig. 3 MRCP: Pancreatic head mass and CBD dilation

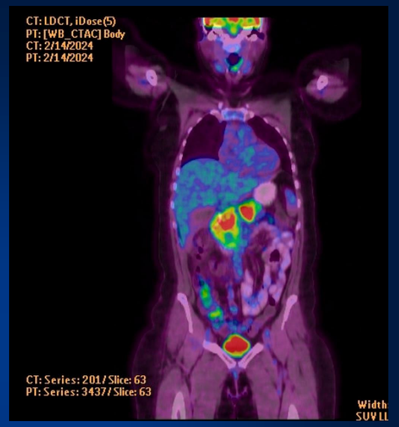

Fig.2 PET scan: Increased uptake in pancreatic head, neck and proximal body

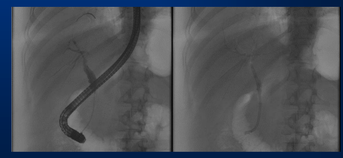

Fig.4 ERCP and CBD stent placement.

Conclusions:

- NKTCL is often associated with Epstein-Barr virus infection, rarely found in the pancreas
- Potential to mimic more common etiologies of an enlarged pancreatic head
- Does not typically present as acute pancreatitis
- Malignancy, including lymphoma, should remain on the differential for acute pancreatitis if no history of new medications, alcohol use or cholelithiasis