Acute Pancreatitis Precipitated by Pancreatic Plasmacytoma

Umer Ejaz Malik, MD[1], Sonia Samuel, DO[2], Liz Sullivan MD[3], Stephen Hasak, MD, MPH[1]

[1]Department of Gastroenterology & Hepatology. Albany Medical Center, Albany, NY

[2]Department of Internal Medicine. Albany Medical Center, Albany, NY

[3]Department of Pathology & Laboratory Medicine. Albany Medical Center, Albany, NY

INTRODUCTION

Pancreatic plasmacytoma is rare entity of an extramedullary plasmacytoma defined as a plasma cell tumor occurring outside the bone marrow. It can present as a solitary plasma cell neoplasm but can also be associated with multiple myeloma. We present a case of pancreatic plasmacytoma in a patient with recurrent abdominal pain who initially presented with acute pancreatitis of unclear etiology.

CASE REPORT

A 58-year-old female with a past medical history of multiple myeloma status post bone marrow transplant with relapse treated with pomalidomide presented with abdominal pain and failure to thrive. She was recently discharged from an outside facility treated for acute pancreatitis where she was found to have an elevated lipase. Laboratory workup was concerning for gallstone pancreatitis. Computed tomography (CT) scan of the abdomen and pelvis showed peripancreatic fluid collection which was further investigated with magnetic resonance cholangiopancreatography (MRCP) revealing a 6.6 x 5.1 x 7.0 cm large pancreatic head mass obstructing a 9.5 mm dilated common bile duct (CBD) and 8 mm dilated pancreatic duct.

LABORATORY WORK-UP	
Lipase (U/L)	9675
ALP (IU/L)	532
AST (IU/L)	475
ALT (IU/L)	422
Total Bilirubin (mg/dl)	1.4

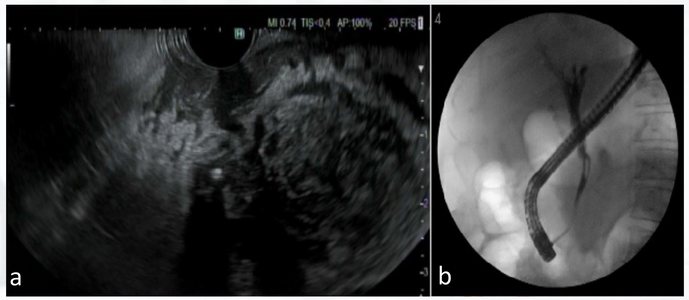

Figure 1. (a) EUS with irregular mass. (b) ERCP demonstrating distal CBD stricture.

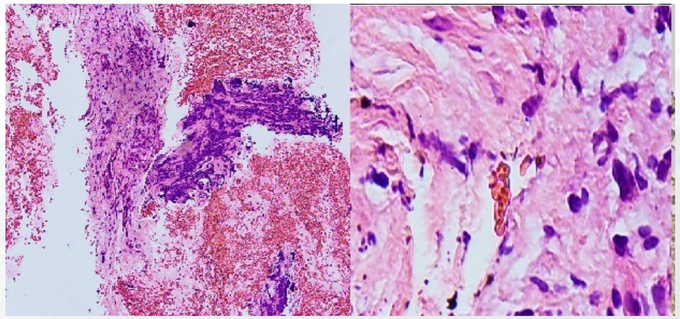

Figure 2. Hematoxylin and Eosin stain. Pancreatic biopsy with marked infiltration by neoplastic plasma cells.

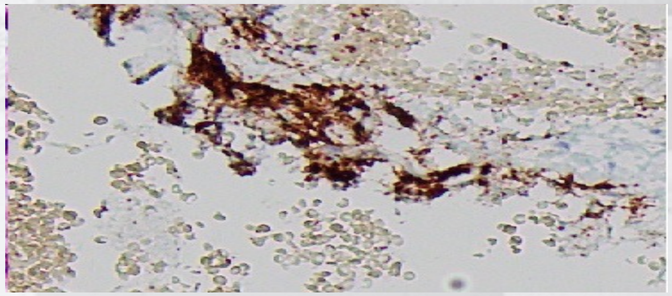

Figure 3. The neoplastic cells exhibiting positive CD138.

CASE REPORT (Continued)

Due to concern for malignancy, endoscopic ultrasound (EUS) was performed and revealed a 6.0 x 5.2 cm irregular hypoechoic pancreatic lesion with fine needle biopsy (FNB) taken of the lesion. Endoscopic retrograde cholangiopancreatography (ERCP) demonstrated a distal CBD stricture and plastic stent was placed.

Pathology results of the pancreatic mass revealed plasma cell neoplasm consistent with patient's history of multiple myeloma. The patient unfortunately passed away within 3 months of findings before further medical intervention.

DISCUSSION

Acute pancreatitis is most commonly precipitated by alcohol use and gallstones but many cases have an unclear etiology. Literature suggests multiple myeloma is associated with acute pancreatitis but there is scarce data on pancreatic plasmacytoma precipitating acute pancreatitis. Typically, plasma cells cause microscopic infiltration of the pancreas and therefore, the presence of an obstructing pancreatic mass is unusual such as in this case. Our case highlights the importance of recognizing pancreatic plasmacytoma as a precipitant of acute pancreatitis due to its obstructive capability in patients with a long-standing history of relapsed multiple myeloma.