Abdominal radiology

Lymphoepithelial cyst of the pancreas: radiological and pathological findings

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To our knowledge, only 16 cases of pancreatic lymphoepithelial cyst have been previously reported and in only 3 of them have the radiological features been described [4-6].

Case report

A 74-year-old woman with a history of two previous transient ischaemic attacks complained of constipation for 15 years duration, worsening during the previous 3 weeks (two evacuations/week). The patient underwent gastro-duodenal and colic endoscopy with normal findings. At hospitalisation, laboratory parameters were normal except for mildly elevated values of blood sugar and erythrocyte sedimentation rate; only CA 19-9 was found in high concentration in the blood: 1206 U/ml (normal range, 0-37 U/ml).

Ultrasonography demonstrated a large, apparently solid mass originating from the pancreatic body and expanding anteriorly and to the left (Fig. 1).

CT examination (intravenous non-ionic contrast medium, scan thickness 5 mm) disclosed a 9-cm hypodense polycystic mass with homogeneous content between the pancreatic body, the left lobe of the liver and the lesser gastric curve (Fig. 2). At the centre of the lesion a stellate hyperdense formation, with a thin inner calcification, was observed corresponding to a central fibrous scar. The pancreatic duct was not dilated and the head of the pancreas appeared homogeneous. No pathological lymph nodes were detected and the portal system was patent.

Thus the CT findings, in accordance with the elevated serum CA 19-9, were suggestive of a mucinous cystic tumour. In order to exclude malignant transformation CT-guided fine-needle biopsy was performed, obtaining 5 ml of creamy yellowish fluid. The cyst fluid carcinoembryonic antigen (CEA) and CA 19-9 titres were only slightly elevated, being respectively 35 ng/ml (normal range: 0-5 ng/ml) and 64 U/ml (normal range: 0-37 U/ml).
US shows an isoechoic, well-defined mass (M), arising from the pancreatic body (P) and extending anteriorly to the abdominal wall. The stomach (S) is displaced to the left and backwards. The arrow points to the upper mesenteric artery.

CT scan, performed during intravenous infusion of contrast medium, confirms the presence of the mass that, contrary to the US findings, appears as a multiloculated lesion with thin walls and a central fibrous scar (arrowheads). Note also the small central calcification (arrow).

Smear of material obtained by fine-needle aspiration of the cystic mass: on a background of plate-like cholesterol crystals, numerous fragments of anucleate cells were present (Giemsa, × 100).

After dissection of the gastrocolic ligament, the multicystic lesion can be seen, protruding within the lesser sac.

Gross pathology: the specimen appears as a smooth-walled multiloculated cyst filled with yellowish friable material.

Histology: the cyst wall is formed by keratinised stratified squamous epithelium surrounded by lymphoid tissue (H&E, × 4).