CASE DESCRIPTION/METHODS: This is a case of a 46-year-old female with a medical history of diabetes mellitus and obesity. Her medical history was significant for obesity, hypertension, hypoglycemia. Liraglutide delays the movement of food from the stomach into the small intestine which causes early satiety and a decrease in appetite.

INTRODUCTION: Liraglutide is a GLP -1 agonist, a class of type two diabetes mellitus injectable treatments, which has shown benefits of controlling blood glucose levels with a minimal risk of hypoglycemia. Liraglutide delays the movement of food from the stomach into the small intestine which causes early satiety and a decrease in appetite.

CASE DESCRIPTION/METHODS: A 40-year-old female presented to the emergency department with a two-day history of acute onset of sharp epigastric pain radiating to the back associated with nausea. The lipase level was elevated at 1,595 U/L and triglycerides were normal. Upon further evaluation, right upper quadrant ultrasound revealed cholestasis. CT abdomen and pelvis revealed cholestasis without evidence of cholecystitis. Magnetic Resonance Cholangiopancreatography (MRCP) showed gallstones and mild gallbladder wall thickening. There were no signs of pancreatic ductal dilatation or mass lesions. The patient’s medical history was significant for obesity, hypertension and asthma. Liraglutide injections were started four weeks prior to her presentation for weight loss.

DISCUSSION: Somatostatinomas, especially in the ampullary region, may present as painless jaundice leading to acute biliary pancreatitis. Interestingly, even after patient was lost to follow up for 2 years, she did not develop metastatic disease which is usually found with first presentation of the disease. Nevertheless, due to high metastatic potential every case when possible should be treated radically and pancreaticoduodenectomy is the treatment of choice.
A Prognosis Worse Than Pancreatic Adenocarcinoma—Metastatic Pancreatic Adenosquamous Carcinoma

Geourie Dharmavaram, BS1, Raj Shah, MD2, Jezy Carcinoma

Acute pancreatitis is an inflammatory disease of the pancreas. Etiologies most commonly include gallstones or alcohol use. In cases where there is no history of alcohol use or obstructive gallstone disease it is imperative to search for alternative causes. In the case we presented, the patient underwent MRCP which did not reveal signs of pancreatic ductal obstructions. A careful review of her medical history and subsequent workup revealed a second primary malignancy. Liraglutide has been reported to cause acute pancreatitis. It has been suggested that it is more common to develop acute pancreatitis while on liraglutide in patients who have a history of pancreatitis or gall bladder disease.

DISCUSSION: Acute pancreatitis is often caused by acute alcohol, gallstone disease, or medications. Liraglutide, a glucagon-like peptide-1 receptor agonist, has been reported to cause acute pancreatitis. It has been suggested that it is more common to develop acute pancreatitis while on liraglutide in patients who have a history of pancreatitis or gall bladder disease.

B Cell Lymphoma Masquerading as a Pancreatic Mass With Pancreatitis

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CASE DESCRIPTION/METHODS: A 42-year-old female with Stage IV B cell lymphoma initially presenting with acute pancreatitis. Initial CT Imaging demonstrated a mass in the pancreatic head concerning for pancreatic adenocarcinoma. The patient was initially treated with chemotherapy consisting of R-CHOP (Rituximab, Cyclophosphamide, Adriamycin, Vincristine, and Prednisone). The patient had a partial response with improved acute pancreatitis. Repeat CT imaging demonstrated a 2.6 cm ill-defined hypervascular mass at the level of the pancreatic head. EUS FNA revealed T-cell lymphoma with small lymphocytic component. Repeated MRCP demonstrated persistence of pseudocyst with wall calcification and new 0.9 mm stricture at the mid-common bile duct with dilation of the main pancreatic duct.

DISCUSSION: Lymphoma involving the pancreas is an unusual presentation of extranodal disease. Given the rarity of this diagnosis and the rapid deterioration of our patient, further information on pathogenesis and serum markers of lymphoma is necessary for improved risk stratification and better treatments for this poorly understood entity.

LEMMER SYNDROME IN A CENTENARIAN

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INTRODUCTION: Lemmer Syndrome is a rare disease of unknown etiology. It is characterized by painful episodic diarrhea and/or malabsorption. It is more commonly seen in the elderly. It has been described in only a small number of cases in the literature. The exact mechanism of action is not fully understood. There are several theories proposed, including nerve entrapment, increased enterocyte permeability, and bacterial overgrowth.

CASE DESCRIPTION/METHODS: A 101-year-old female with a history of hypertension, hyperlipidemia, smoking, and alcohol use presented with epigastric pain radiating to the back. She underwent abdominal CT scan which showed an inflammatory mass with irregular margins and peripancreatic lymphadenopathy concerning for metastatic disease. EUS demonstrated a hypoechoic lesion in the pancreatic head with peripancreatic lymphadenopathy. The patient was treated with chemotherapy consisting of R-CHOP (Rituximab, Cyclophosphamide, Adriamycin, Vincristine, and Prednisone). She had a partial response with improvement in symptoms. Repeat CT imaging demonstrated persistence of the lesion with new peripancreatic lymphadenopathy. The patient had no symptoms prior to her presentation with acute pancreatitis. Her Ca19-9 was elevated, probably secondary to her recent acute pancreatitis. Her tumor responded to dose adjusted R-EPOCH (Rituximab, Etoposide, Prednisone, Oncovin, Cyclophosphamide, and Hydroxydaunorubicin).

DISCUSSION: Non-Hodgkin’s lymphoma secondarily involving the pancreas initially presenting as acute pancreatitis is extremely rare. Among 50% of patients with non-Hodgkin’s lymphoma present with extranodal disease, pancreatic involvement represents only about 0.2% to 2% of cases. Primary pancreatic lymphomas are extremely rare but more often present with acute pancreatitis than secondary pancreatic non-Hodgkin’s lymphoma.

To our knowledge, there are less than 15 reported cases of non-Hodgkin’s lymphoma with secondary involvement of the pancreas presenting as acute pancreatitis. This case demonstrates the need to keep the differential diagnosis broad in the evaluation of pancreatic masses causing pancreatitis even in what seems to be a straightforward case.