

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

ScienceDirect

journal homepage: <http://www.kjms-online.com>

## LETTER TO THE EDITOR

# Extremely rare cause of obstructive jaundice: Non-neoplastic, noninfectious lymphadenitis



To the Editor,

The most common cause of biliary obstruction is cholelithiasis. Intrinsic narrowing of bile ducts by inflammation, infection, and neoplastic biliary disease are also common [1]. Obstructive cholangitis is frequently the first presentation of cholangiocarcinoma or pancreatic cancer, especially if the tumor is in the pancreatic head and

ampulla of vater. Obstructive cholangitis caused by lymphadenopathy is relatively rare. Malignant lymphadenopathy, including metastatic lymphadenopathy or lymphoma, is more frequent than benign lymphadenopathy [2,3]. Infectious lymphadenitis, such as tuberculosis or cat scratch disease, is a rare cause of obstructive cholangitis [4]. Here, we present a unique case with obstructive



**Figure 1.** Axial T2-weighted turbo spin-echo (2,000/100) MR images show (A,B). One well defined high signal intensity mass (white arrow in A) above the pancreatic head (white arrow in B) with adjacent upstream common bile duct dilatation (white arrowhead in A). Coronal T2-weighted turbo spin-echo (2,000/80) MR image shows (C). The well defined high signal intensity mass (white arrow) compressed the adjacent common bile duct (arrow) with upstream biliary ducts dilatation (white arrowhead).

Conflicts of interest: All authors declare no conflicts of interests.

<http://dx.doi.org/10.1016/j.kjms.2015.04.009>

1607-551X/Copyright © 2015, Kaohsiung Medical University. Published by Elsevier Taiwan LLC. All rights reserved.

cholangitis with jaundice caused by non-neoplastic, noninfectious lymphadenopathy.

A 20-year-old woman visited our out-patient department with presentation of nausea, poor appetite and mild epigastralgia occasionally for several months. A esophagogastroduodenal scopic examination was performed and the result revealed duodenal ulcer with gastritis and reflux esophagitis. Although symptoms and signs improved under antiulcer management, elevated transaminase was found at routine check up: aspartate aminotransferase, 172 IU/L and alanine transaminase, 334 IU/L; bilirubin level, 2.23 mg/dL; cancer antigen 19-9, < 15 U/mL;  $\alpha$ -fetoprotein, < 3.0 ng/mL; anti-hepatitis C virus, negative; and hepatitis B virus surface antigen, negative.

Abdominal ultrasound revealed a pancreatic nodule with compression dilatation of the common bile duct. Abdominal magnetic resonance imaging (Fig. 1) further documented the lesion near the pancreatic head with a dilatation of the common bile duct and intrahepatic bile duct. Endoscopic retrograde cholangiopancreatography demonstrated focal bile duct narrowing, which was suspected to be due to external compression.

After discussion with the patient and her family, laparotomy was done for operation biopsy and removal of the tumor. The frozen pathology in the operation did not find any malignant cells, so partial removal of lymphadenopathy was performed. The final pathological report demonstrated chronic lymphadenitis without malignancy, signs of tuberculosis, virus, or other pathogen. After the operation, the liver function returned to normal range (aspartate aminotransferase, 20 IU/L; alanine transaminase, 29 IU/L; and bilirubin, 0.7 mg/dL) at following laboratory examination. Abdominal ultrasound had the same bile duct dilatation, and the transaminases and bilirubin were all within normal range during the following 14 years.

In conclusion, lymphadenopathy is an uncommon cause for obstructive cholangitis with jaundice. Although there are too few cases for prevalence and incidence to be determined, malignancy was the most frequent etiology, followed by infection. Other causes are extremely rare. In a patient with obstructive cholangitis and jaundice, surgical

intervention is necessary for histology and for relief of obstructive cholangitis.

## References

- [1] Peyré CG, Wakim M, Mateo R, Genyk Y, Singh G, Selby RR, et al. Unusual cases of jaundice secondary to non-neoplastic bile duct obstruction. *Am Surg* 2004;70:620–4.
- [2] Joo YE, Park CH, Lee WS, Kim HS, Choi SK, Cho CK, et al. Primary non-Hodgkin's lymphoma of the common bile duct presenting as obstructive jaundice. *J Gastroenterol* 2004;39:692–6.
- [3] Wang YJ, Jeng CM, Wang YC, Chang PP, Wang TH. Primary pancreatic Burkitt's lymphoma mimicking carcinoma with obstructive jaundice and very high CA19-9. *Eur J Gastroenterol Hepatol* 2006;18:537–40.
- [4] van Beek EJ, Smits NJ, Reeders JW. Cat scratch disease as a rare cause of obstructive jaundice: a case report. *Abdom Imaging* 1997;22:418–20.

Yi-Hung Lin

*Division of Hepatobiliary, Department of Internal Medicine, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan*

Kun-Bow Tsai

*Department of Pathology, Kaohsiung Municipal Hsiao-Kang Hospital, Kaohsiung, Taiwan*

*Faculty of Pathology, College of Medicine, Kaohsiung Medical University, Kaohsiung, Taiwan*

Shinn-Cherng Chen\*

Wan-Long Chuang

*Division of Hepatobiliary, Department of Internal Medicine, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan*

*Faculty of Internal Medicine, College of Medicine, Kaohsiung Medical University, Kaohsiung, Taiwan*

\*Corresponding author. Division of Hepatobiliary, Department of Internal Medicine, Kaohsiung Medical University Hospital, 100 Tzyou 1st Road Kaohsiung 807, Taiwan. E-mail address: [chshch@cc.kmu.edu.tw](mailto:chshch@cc.kmu.edu.tw) (S.-C. Chen)