中文題目：胰臟內副脾

英文題目：Intrapancreatic accessory spleen

作　　者：何家瑋[1], 魏亦伸[2]

服務單位：[1]台北市立聯合醫院仁愛院區內科部,[2]台北市立聯合醫院仁愛院區消化內科

Introduction: The presence of an accessory spleen has been reported in 10% to 30% of cases in postmortem studies and in 45% to 65% of patients after splenectomy. The locations of accessory spleens vary, i.e., the splenic hilum, the tail of the pancreas, the greater omentum, the splenic ligament, the small and large intestinal mesentery, the wall of the small intestine, the female adnexa and the scrotum in descending order of prevalence. We herein present a patient with intrapancreatic accessory spleen with initial presentation of upper abdominal fullness and dyspepsia for 6 months.

Case presentation: This is a 63-year-old man with past history of chronic hepatitis B carrier, hypertension. He received health checkup in Oct. 2019. Chest CT showed suspected 3.4 x 1.9 cm ill-defined soft tissue in pancreatic tail. He had upper abdominal fullness and dyspepsia for 6 months. He denied bowel habit change, fever, tea color urine, body weight loss in 3 months. Previous abdominal CT on Feb. 2016 reported no pancreatic tail enlargement. Therefore, he went to our GS OPD for help. Physical examination showed no tenderness, no abdominal palpable mass, no palpable lymph node. Lab data reported CA 199: 9.8 U/ml, CEA: 4.2 ng/ml, T.bil: 0.26 mg/dl, Cr: 1.0 mg/dl, Hb: 12.7g/dl, plt: 260k/ul. Abdominal MRI on Oct. 2019 showed one 3x2x2cm low T1 & iso-T2 & enhanced lesion in pancreatic tail, without persistent high DWI SI, malignancy cannot be ruled out. He received laparoscopic partial pancreatectomy and splenectomy on 2019/11/22. Pathology reported ectopic spleen in pancreas.

Discussion: Intrapancreatic accessory spleen (IPAS) is a benign, hypervascular tumor. IPAS usually pose no clinical problem and detected as incidentally pancreatic nodule. However, IPAS is challenging to identifying using medical imaging. IPAS is often misdiagnosed as other hypervascular pancreatic tumors, including islet cell tumor, hypervascular metastasis. Inhomogeneous enhancement of an IPAS in its early phases and clearly high SI in DWI may be diagnostic clues. No treatment is necessary for IPAS, except for symptomatic (eg. torsion, rupture, hemorrhage, ITP) or mimics with other pancreatic tumor.

Conclusion: IPAS usually pose no clinical problems, it is important to characterize accessory spleens as noninvasively as possible.