Letters to the Editor

Pancreatic panniculitis

Sir,

We read with a great deal of interest the article titled "Panniculitis-polyarthritis-pancreatitis syndrome" by Kashyap *et al*., which describe the rare association of panniculitis with pancreatic pathology.[1] However, we would like to make the following observations.

Panniculitis is an inflammation of the subcutaneous fat that can be associated with erythema nodosum, erythema induratum, Weber–Christian panniculitis, lupus panniculitis, alpha-1-antitrypsin deficiency and pancreatic disease including pancreatic neoplasms. Clinically, panniculitis presents with erythematous, ill-defined, reddish-brown, painful or painless nodules which appear on the arms, trunk, thighs, and breast. Chiari first described the association between pancreatic disease and subcutaneous fat necrosis in 1883. The subcutaneous nodules associated with pancreatic disease can precede, occur concurrently with or follow the pancreatic pathology. Pancreatic panniculitis can be associated with pancreatic malignant tumors (acinar cell carcinoma in 80% of the cases), and with acute or chronic pancreatitis. Distinctive laboratory values in pancreatic panniculitis include eosinophilia and elevated serum lipase levels.[2] Panniculitis in association with polyarthritis and eosinophilia is known as Schmid's triad and shows a poor prognosis.[3]

The pathogenesis of pancreatic panniculitis is not unraveled but saponification of fat secondary to the action of liberated pancreatic lipase and elastase I is a postulated mechanism. Histopathologically, pancreatic panniculitis is characterized by lobular fat necrosis with anuclear adipocytes, called ghost cells, within a thick, shadowy wall with or without focal calcification and a mixed inflammatory infiltrate.[2]

In the article by Kashyap *et al*., it appears that authors are describing the association of panniculitis with alcohol-induced mass forming chronic pancreatitis. The final diagnosis is unclear since there is no mention about the histopathology of the mass. Although, both chronic pancreatitis- associated mass and carcinoma head pancreas may present with similar symptoms and signs, lack of calcification in the pancreatic parenchyma or within the mass, absence of atrophy of the parenchyma and smooth dilation of the pancreatic duct make chronic pancreatitis-associated mass less likely.[4]

In chronic pancreatitis, the dilated duct is typically irregular with strictures and contains calcification.[4] Moreover, the patient in the described case was known to have had a single episode of pancreatitis without any exocrine or endocrine insufficiency which itself negates the possibility of chronic pancreatitis.

Quite often, pancreatic tumor manifests itself as acute pancreatitis.[5] Such a clinical setting in an elderly person with imaging features of mass in the pancreatic head (that lacks features of chronic pancreatitis-associated mass as described above) should prompt endoscopic ultra sound (EUS)/endoscopic retrograde cholangio-pancreatography (ERCP)-guided biopsy before any surgery is contemplated.

The authors mention that the X-rays of the joint was normal but correlating with the description and clinical images provided in the article, the X-rays would at least reveal abnormal soft tissue swelling around the joint with displacement of fascial planes. The diagnosis of pancreatic panniculitis was established on biopsy. The biopsywas,however,followedbyultrasonography-guided aspiration. We wonder if there was any additional benefit of performing guided aspiration after biopsy, which is a gold standard for diagnosis. Similarly, if the authors thought the pancreatic mass to be malignant, serum measurement of CA 19-9 should have been done instead of carcinoembryonic antigen since the former has a specificity and sensitivity of 90% and is also widely used.[5] Furthermore, carcinoembryonic antigen can be increased in a numberof tumors other than pancreatic carcinoma. Lastly, the pancreatic duct has been erroneously labeled as common bile duct (CBD) in the provided images.

Sarita Kalwaniya, Pradeep Choudhary[1], Yashant Aswani[2], Suresh Jain

Department of Dermatology, Venerology and Leprology, Departments of Radiodiagnosis, [1]Government Medical College Kota, Rajasthan, [2]Seth GS Medical College and KEM Hospital, Mumbai, Maharashtra, India

Address for correspondence: Dr. Sarita Kalwaniya,
Mirdha Nagar, Didwana Road, Kuchaman City,
Nagaur, Rajasthan - 341 508, India.
E-mail: sarita.pawariya@gmail.com

REFERENCES

1. Kashyap S, Shanker V, Kumari S, Rana L. Panniculitis-polyarthritis-pancreatitis syndrome. Indian J Dermatol Venereol Leprol 2014;80:352-4.
2. Moro M, Moletta L, Blandamura S, Sperti C. Acinar cell carcinoma of the pancreas associated with subcutaneous panniculitis. JOP 2011;12:292-6.
3. Agrawal PG, Khopkar US, Mahajan SA, Mishra SN. Triads in Dermatology. Indian J Dermatol 2013;58:346-51.
4. Sainani N, Catalano O, Sahani D. Pancreas. In: Haaga JR, Dogra VS, Forsting M, Gilkeson RC, Ha HK, Sundaram M, Editors. CT and MRI of the whole body. 5th ed. Philadelphia: Mosby Elsevier; 2009. p. 1599-674.
5. Chua YJ, Cunningham D. Pancreatic cancer. In: Fauci AS, Braunwald E, Kasper DL, Hauser SL, Longo DL, Jameson JL, *et al*. Editors. Harrison's principles of internal medicine. 17th ed. United States of America: McGraw-Hill Companies, Inc: 2008. p. 586-9.

Access this article online	
Quick Response Code:	Website: www.ijdvl.com
	DOI: 10.4103/0378-6323.155578