Cholecystitis
- acute
- chronic

Gallbladder tumors
- Adenomyoma (benign)
- Adenocarcinoma

Pancreatitis
- acute
- chronic

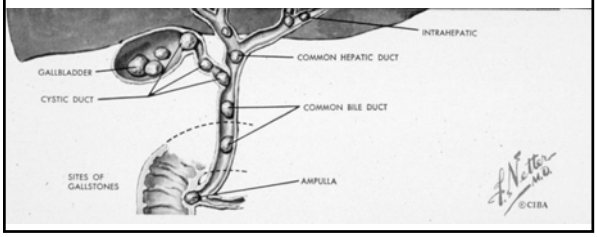
Pancreatic tumors

Intro to Gallbladder & Pancreas Pathology

Helen Remotti M.D.

Choledocholithiasis
(Stones in the common bile duct)

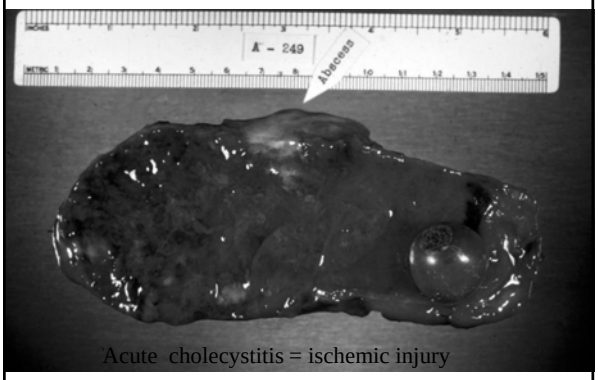
Pain: Epigastric, RUQ-stones may be passed
Obstructive Jaundice-may be intermittent
Ascending Cholangitis- Infection: to liver
20%: No pain; 25% no jaundice



Gallstones
(Cholelithiasis)

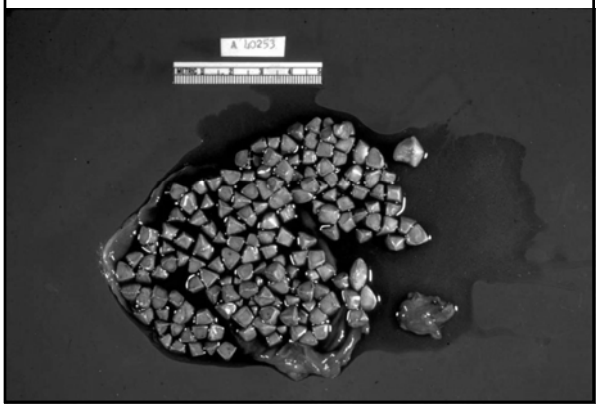
- 10 - 20% Adults
- 35% Autopsy: Over 65

- Over 20 Million
- 600,000 Cholecystectomies
- #2 reason for abdominal operations



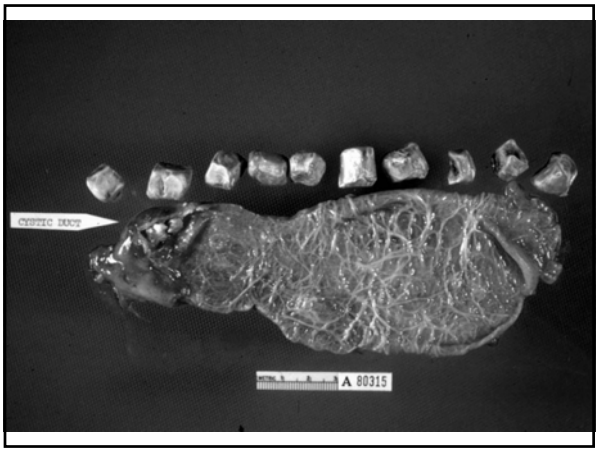
Acute cholecystitis = ischemic injury

Cholesterol/mixed stones



Chronic Cholecystitis

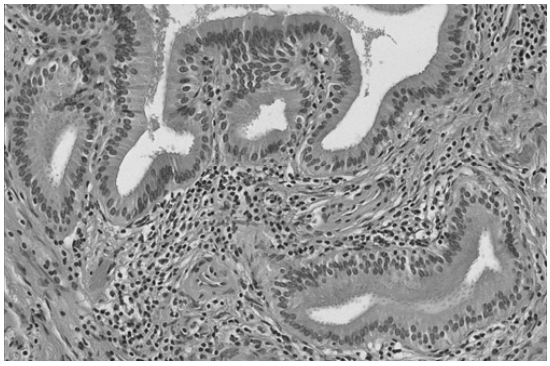
- Associated with calculi in 95% of cases.
- Multiples episodes of inflammation cause GB thickening with chronic inflammation/ fibrosis and muscular hypertrophy.
- Rokitansky - Aschoff Sinuses (mucosa herniates through the muscularis mucosae)
- With longstanding inflammation GB becomes fibrotic and calcified “porcelain GB”



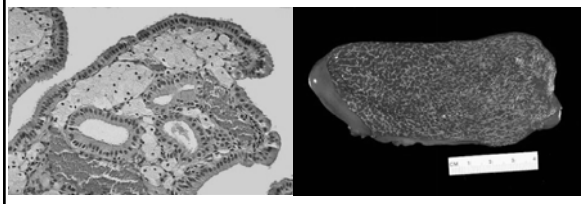
Chronic Cholecystitis

- Fibrosis
- Chronic Inflammation
- Rokitansky - Aschoff Sinuses
- Hypertrophy: Muscularis

Chronic cholecystitis

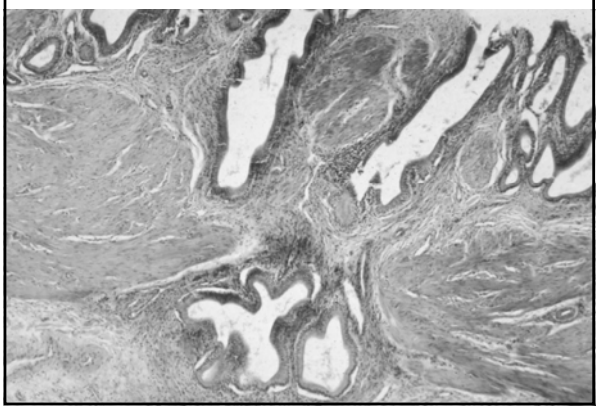


Cholesterolosis

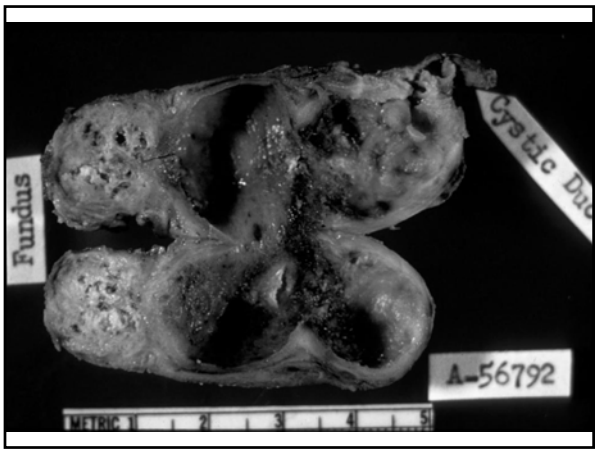


Focal accumulation of cholesterol-laden macrophages in lamina propria of gallbladder (incidental finding).

Rokitansky-Aschoff sinuses



Adenomyoma of Gall Bladder



Carcinoma: Gall Bladder

Uncommon: 5,000 cases / year

Fewer than 1% resected G.B.

Sx: same as with stones

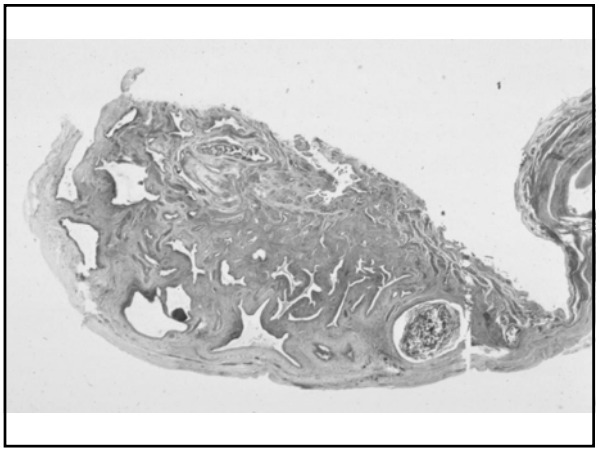
5 yr. survival: Less than 5%

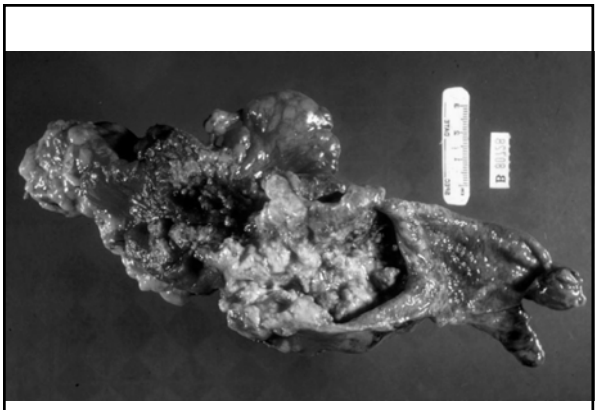
(survival relates to stage)

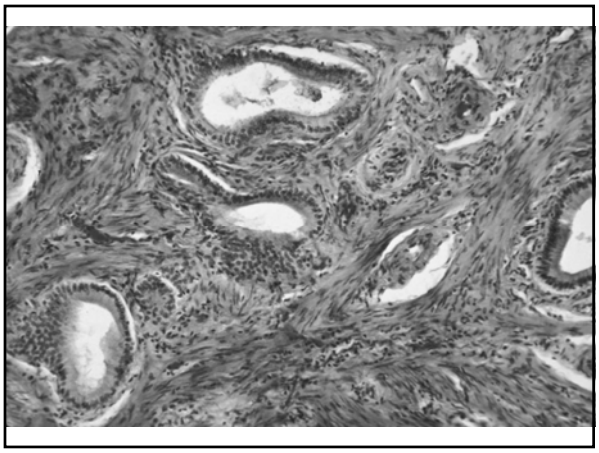
90%: Stones

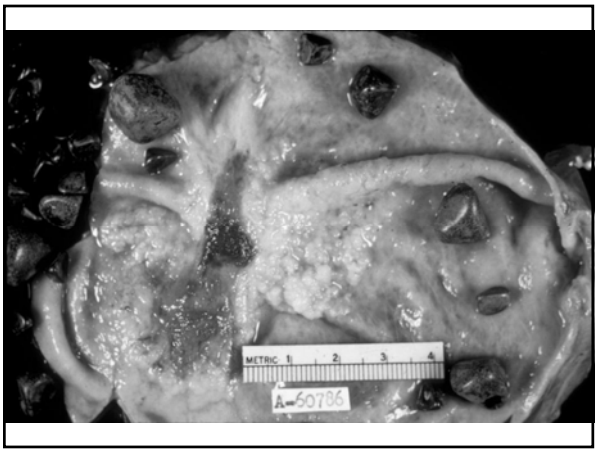
Long Hx: symptomatic stones

Stones: predispose to CA., but uncommon complication

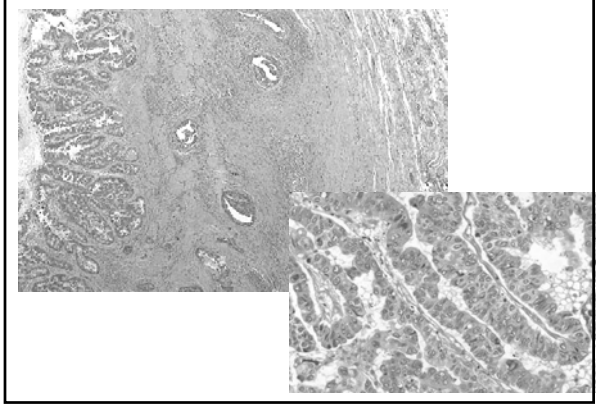


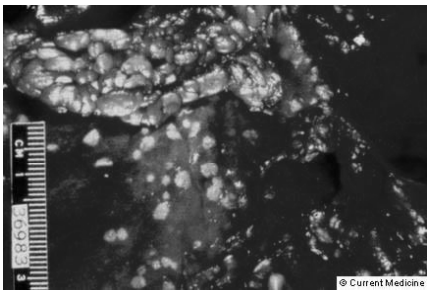






Gallbladder carcinoma





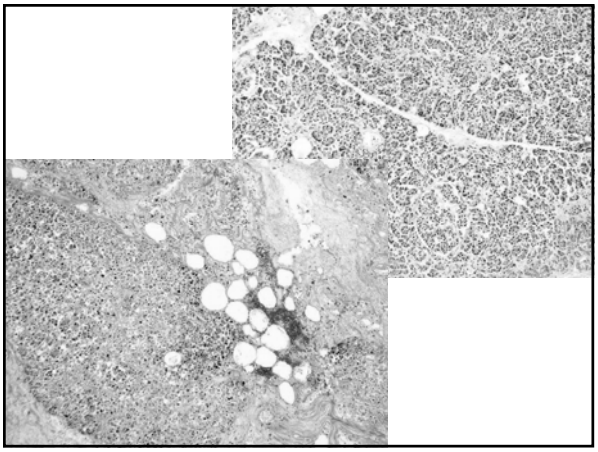
Acute pancreatitis

Case 1

56 year old woman presents to ER in shock, following rapid onset of severe upper abdominal pain, developing over the previous day.

Hx: heavy alcohol use.

LABs: Elevated serum amylase and elevated peritoneal fluid lipase

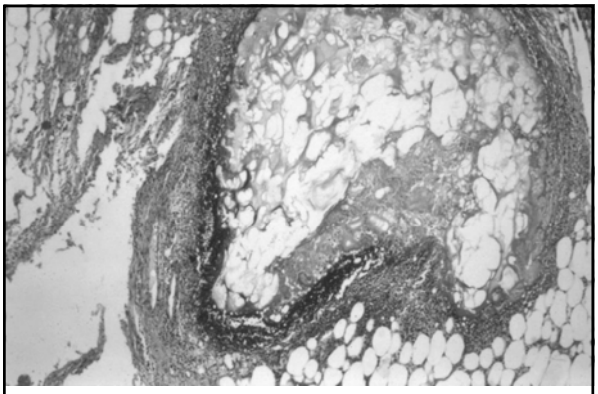


Acute Pancreatitis

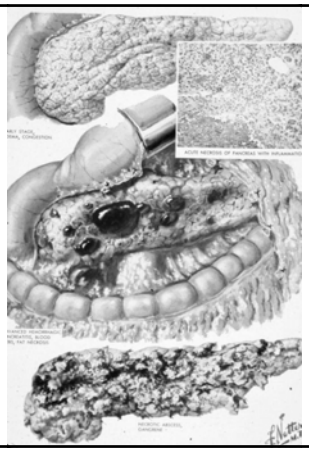
Patient developed rapid onset of respiratory failure necessitating intubation and mechanical ventilation.

Over 48 hours, she was increasingly unstable, with evolution to multi-organ failure, and she expired 82 hours after admission.

An autopsy was performed.



Elastase destruction of blood vessels – with hemorrhage



Acute Pancreatitis

Edema, congestion

Advanced hemorrhagic pancreatitis, fat necrosis

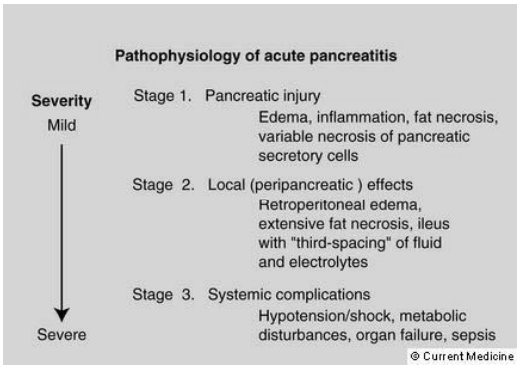
Necrotic abscess, gangrene

Chronic Pancreatitis

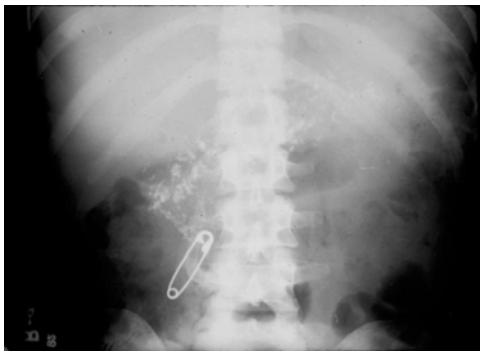
Continuing inflammation with irreversible changes in architecture, structure and function.

Fibrosis of parenchyma with distortion of duct architecture, loss of exocrine secretory function.

Changes may be focal or widespread.



Chronic pancreatitis with Stones



Acute Pancreatitis

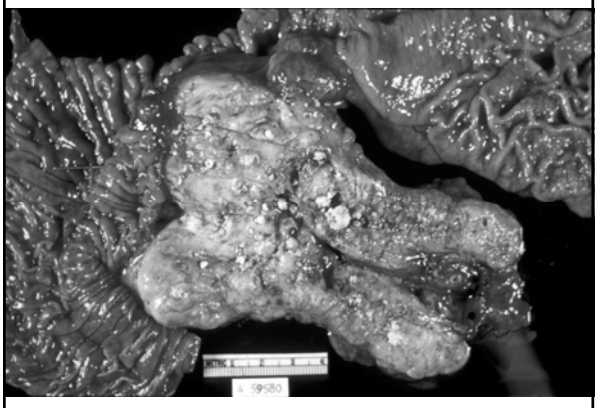
US: 45% of cases have gallstones and choledocholithiasis;

35% associated with heavy alcohol ingestion

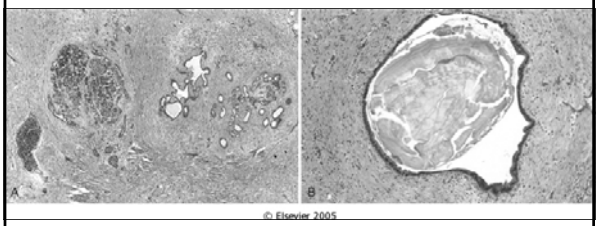
Pathology: Enzyme release is triggered with digestion of pancreas, necrosis of fat and lobules, hemorrhage from damaged blood vessels.

Variable severity: may lead to liquefactive necrosis, hemorrhage.

Mild cases – may have local complications: abscess, pseudocyst.



Chronic pancreatitis



Case 2

67 year old woman with recent onset painless jaundice.

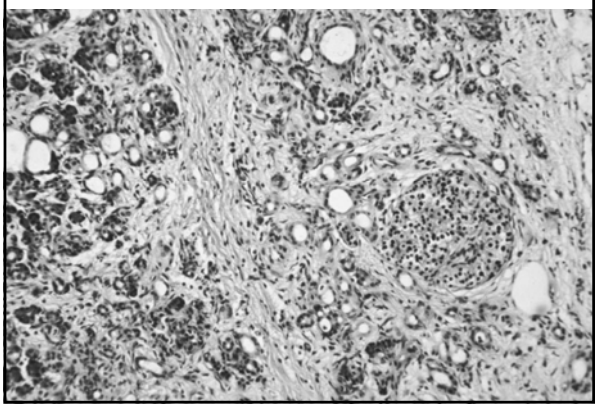
History of 15lb weight loss over last 3 months.

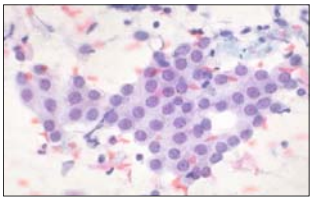
She smoked 1 pack per day x 35 years.
Physical exam: palpable GB

ERCP was performed with Endoscopic Ultrasound (EUS) evidence of a large mass in the head of the pancreas.

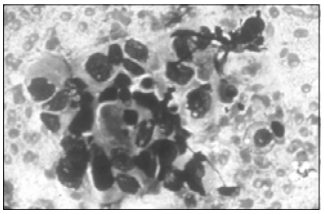
An endoscopic FNA was performed.

Chronic Pancreatitis





Normal pancreas
ductal epithelium



Patient's FNA

Dx: Adenocarcinoma

Complications of Chronic Pancreatitis

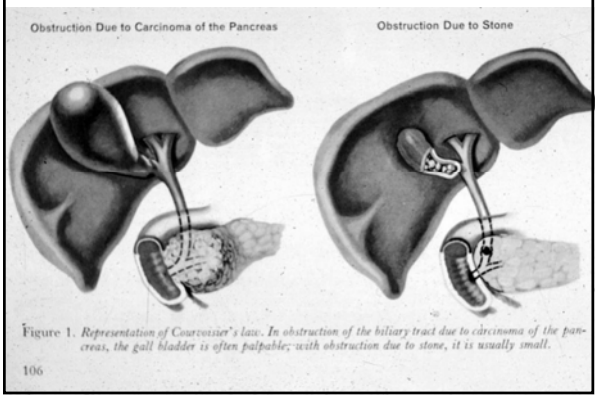
Chronic abdominal pain, severe and unremitting, radiating to back

Malabsorption due to reduced enzyme secretion. (After 90% of pancreas is fibrotic, reduced lipase and trypsin secretion lead to steatorrhea) .

Pancreatic diabetes associated with decreased islets.

Pancreatic pseudocysts with extension or rupture in adjacent organs.

Curvoissier's Law – enlarged palpable GB

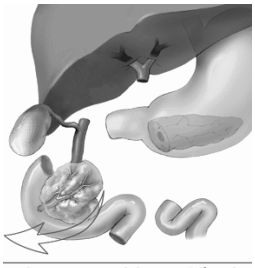


Pancreatic Ductal Adenocarcinoma: Clinical

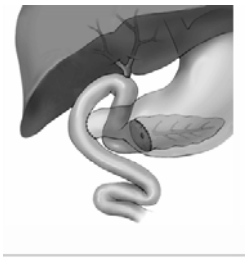
- Represents the most common pancreatic neoplasm
  - 2nd most common GIT cancer
- 4th leading cause of cancer death
- M > F; > 50 years at initial presentation usually
- Symptoms:
  - Abdominal pain, weight loss, jaundice, pancreatic insufficiency, malabsorption; Migratory thrombophlebitis – "Trousseau's sign"
- Site:
  - head (60-70%) > body (10-15%) > tail (5-10%)
- Contributing factors:
  - smoking, carcinogens, genetics

Pancreatic Ductal Adenocarcinoma: Pathology

- Macroscopic:
  - Usually a solitary mass
  - poor demarcation
  - firm to gritty consistency
  - depends upon location, but bile stasis specifically for the head of pancreas neoplasms

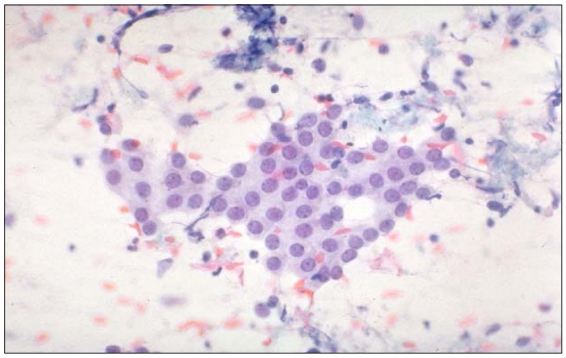


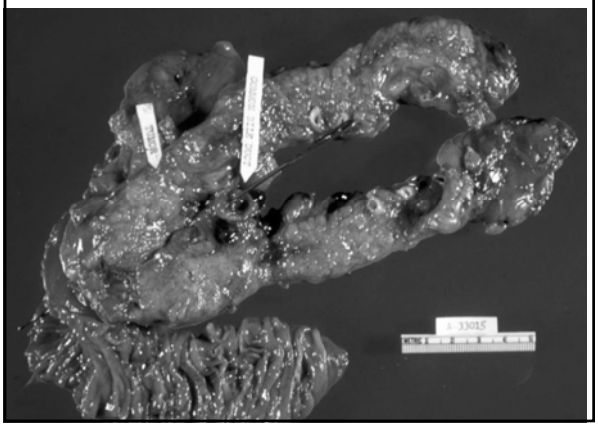
Organs removed during a Whipple



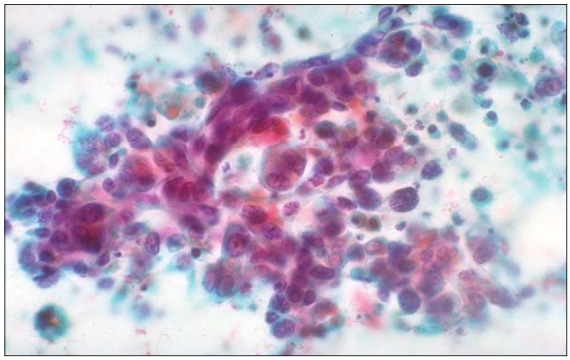
Most common anatomy after Whipple

Chronic Pancreatitis:

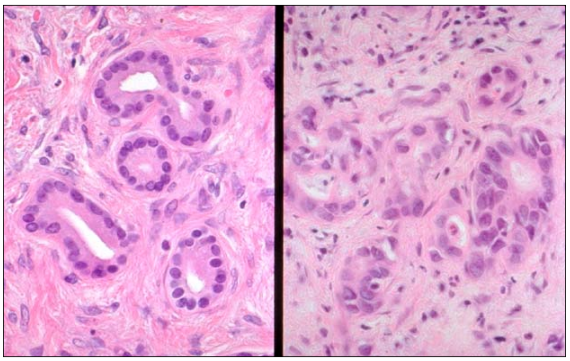




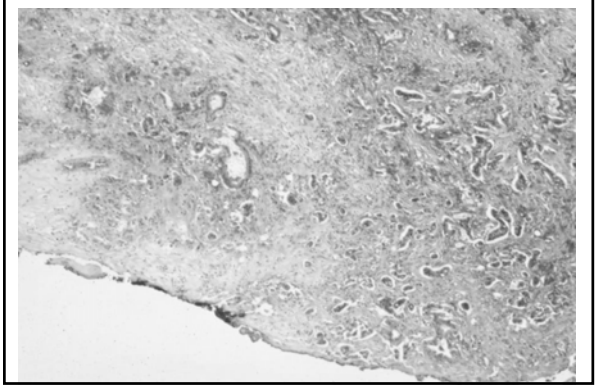
Pancreatic Ductal Adenocarcinoma: FNA



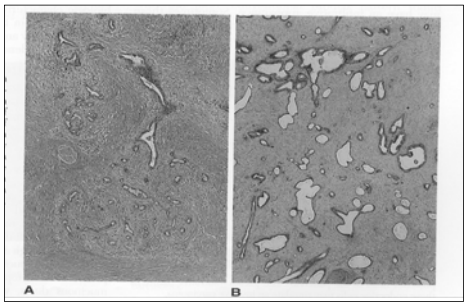
Normal **AdenoCA**



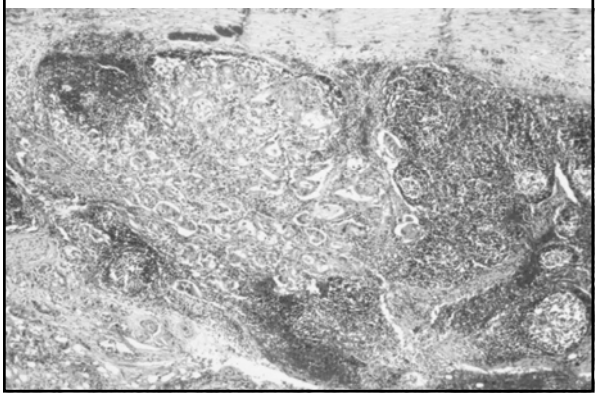
Invasion into peripancreatic soft tissue



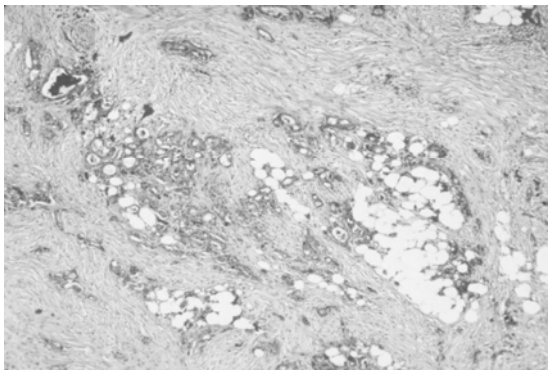
Benign – lobular Malignant- haphazard



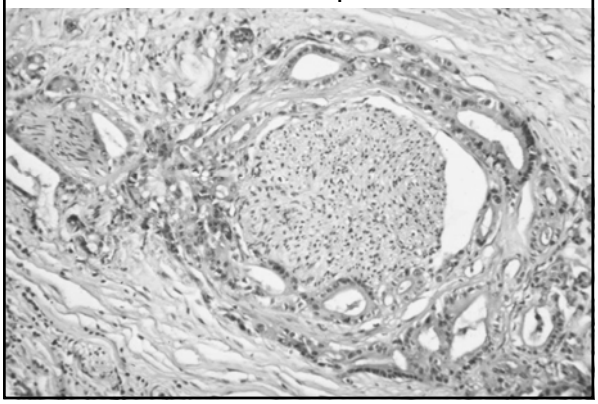
Pancreatic adenocarcinoma – Lymph node metastases



Invasive growth with associated desmoplasia



Pancreatic adenocarcinoma – perineural invasion



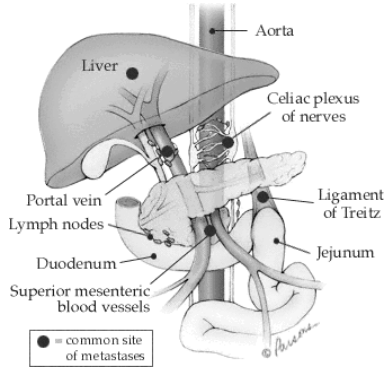
Pancreatic Ductal Adenocarcinoma: Pathology

- Microscopic:
  - loss of lobular architecture
  - architectural and cytomorphologic features indicative of malignancy:
    - loss of cell differentiation, hyperchromatic nuclei, increased N:C, prominent nucleoli, mitotic activity
  - intraductal carcinoma
  - invasive growth associated with desmoplasia
  - neurotropism, extratumoral vascular invasion
  - extension into peripancreatic soft tissue
  - secondary pancreatitis due to obstruction

Definition of Tumor (T)

- **TX** Primary tumor cannot be assessed
- **T0** No evidence of primary tumor
- **Tis** *In situ* carcinoma
- **T1** Tumor limited to the pancreas, 2 cm or less in greatest dimension
- **T2** Tumor limited to the pancreas, more than 2 cm in greatest dimension
- **T3** Tumor extends directly into any of the following: duodenum, bile duct, peripancreatic tissues
- **T4** Tumor extends directly into any of the following: stomach, spleen, colon, adjacent large vessels

Critical area to evaluate- uncinate margin



Margin most likely
To be positive is the
Uncinate margin -
Retroperitoneal/mesenteric
Margin along the right
Lateral border of the SMA
And should be inked.

Pancreatic Cancer Prognosis

- 2 yr survival – 28%
- 5 yr survival – 3-12%

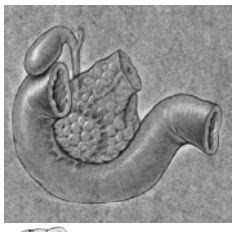
- Mean survival in untreated patients 3 mo.
- Mean survival after radical resection 10-20 mo

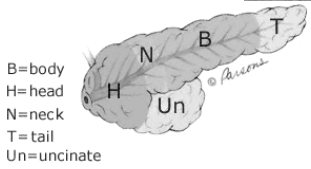
- (Less than 20% of patients are surgical candidates).

Margin evaluation:
Bile duct (Black posterior)
Pancreatic distal (Yellow anterior)
Posterior/Retroperitoneal
Uncinate

Tumor size:
Measure Gross

Submit 2 complete cross sections.





Pancreas Cancer Genetics

5-10% of cases are familial, some with defined genetic syndromes

Hereditary Pancreatitis: germline mutations in trypsinogen gene on 7q35 with 40% lifetime risk of developing pancreatic cancer.

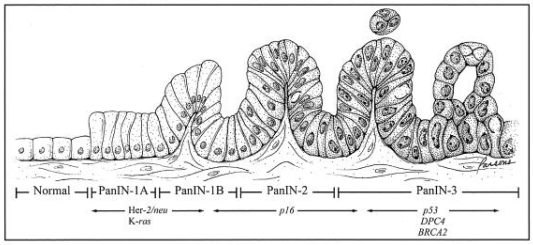
Pancreatic cancers described in BRCA2 mutations in familial breast cancer kindreds.

Associated with germline p16 mutations, and HNPCC.

Role of oncogenes: KRAS-90%, p16-95%, p53-75%

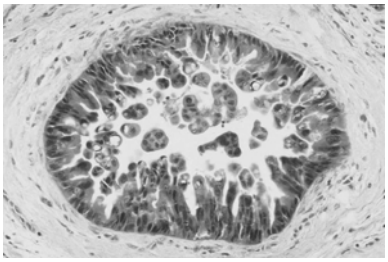
In-situ progression to Cancer

Takaori and Hruban *Pancreas* 2004 28:256-262.



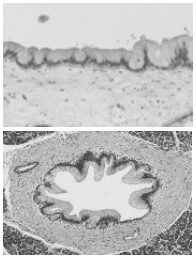
Pan IN (Pancreatic Intraepithelial Neoplasia)

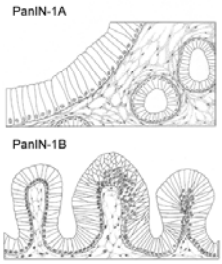
PanIN3 – cribriform, papillary, micropapillary (rarely flat)
(marked loss of polarity, nuclear crowding, enlarged nuclei, pseudostratification, and hyperchromasia, abnormal mitoses)



Pan IN (Pancreatic Intraepithelial Neoplasia)

PanIN-1A-flat epithelium; basal nuclei, abundant supranuclear cytoplasm
PanIN-1B – papillary, micropapillary architecture; cytology same as 1A.



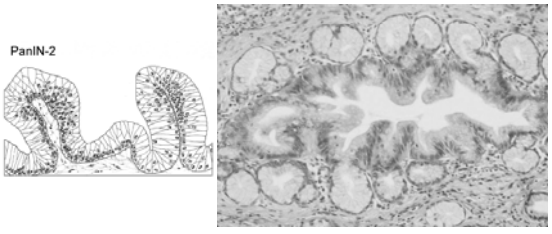


Pancreatic Cystic Lesions

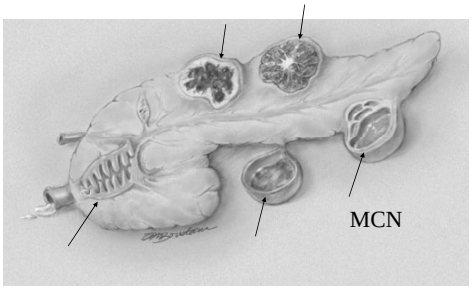
- **Mucinous cystic neoplasm** (benign, borderline or malignant)
- **Intraductal papillary mucinous neoplasm** (benign, borderline or malignant)
- **Serous cystadenoma** (benign)
- **Pseudocyst** (benign – NOT a NEOPLASM)

Pan IN-2 (Pancreatic Intraepithelial Neoplasia "Moderate Dysplasia")

PanIN-2- flat or papillary, micropapillary; some nuclear abnormalities
(some loss of polarity, nuclear crowding, enlarged nuclei, pseudostratification, and hyperchromasia – but less than PanIN-3)

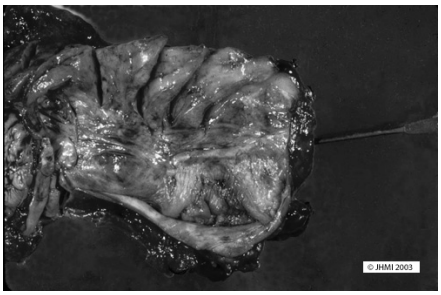


PANCREATIC CYSTIC LESIONS



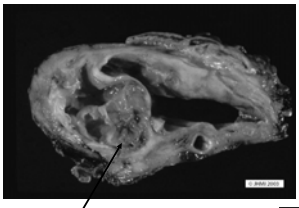
Mucinous cystic Neoplasm

NOT connected with pancreatic ducts!



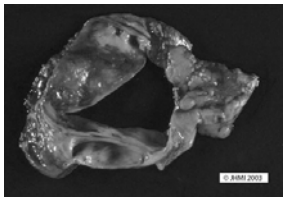
Mucinous Cystic Neoplasms MCNs

Mainly Females (mean age 45)
Abdominal Pain or Mass
Sample extensively to rule out invasive component
Classification: Mucinous cystadenoma (minimal atypia)
Borderline MCN (moderate atypia, papillary architecture)
MCN with CIS (high grade cytology, cribriform architecture)
Invasive CA (destructive stromal invasion, usual ductal CA)
Gross: large (mean 10cm); Body/Tail; Multilocular, unilocular rare
NO communication with pancreatic duct.
Micro: Columnar mucin cells; intestinal or gastric foveolar type.
Ovarian stroma (ER+, PR+, inhibin+)
DD: IPMN (Head/communicate with ducts/ no ovarian stroma)
Pancreatic Pseudocyst (MCN lining can be denuded)



Mucinous cystadenocarcinoma

Mucinous cystadenoma



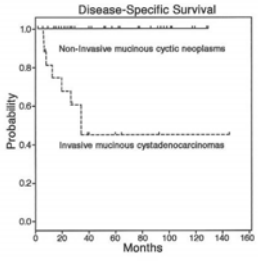
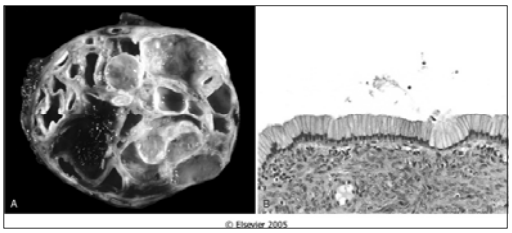


Figure 5-33
DISEASE-SPECIFIC SURVIVAL AFTER SURGICAL RESECTION

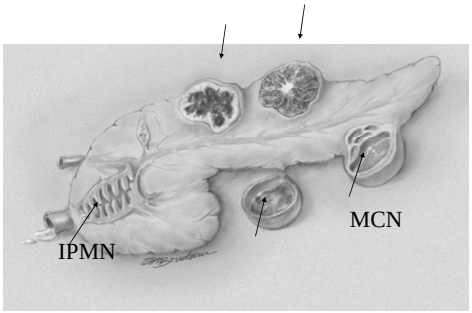
The presence or absence of an associated invasive carcinoma is the best predictor of survival following surgical resection of a mucinous cystic neoplasm. (Fig. 5 from Wilentz RE, Albores-Saavedra J, Zahurak M, et al. Pathologic examination accurately predicts prognosis in mucinous cystic neoplasms of the pancreas. Am J Surg Pathol 1999; 23:1324.)

Mucinous cystic neoplasm

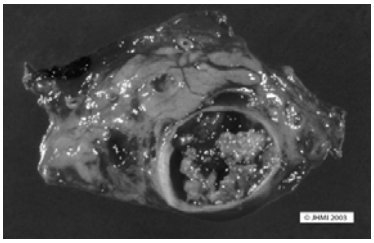


Mucinous epithelium; "ovarian type stroma"
Clinical spectrum: benign to malignant

PANCREATIC CYSTIC LESIONS



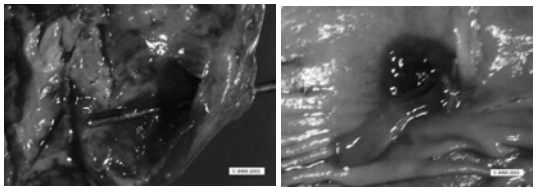
Intraductal Papillary Mucinous Neoplasm (IPMN)



Intraductal Papillary Mucinous Neoplasm (IPMN)

- IPMT (first named in 1995)
- Radiologic or grossly visible lesion (>1cm)
- Contiguous or multicentric with cytologic atypia
- Head of pancreas; More common in male >60 y.
- Invasive tumors associated with 30% of IPMNs (often colloid type – more indolent clinical behavior than usual invasive ductal-NOS.)
- Resection often with frozen sections, since most lesions are contiguous.
- Grade (Benign, Borderline, Intraductal CA);
- DD: Mucinous cystic neoplasms, PanIN (resembles small IPMN)

IPMNs (Intraductal Papillary Mucinous Neoplasms)



Communicates with duct Mucin oozes out of ampullae

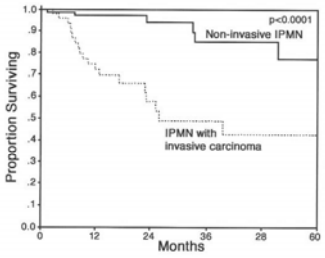
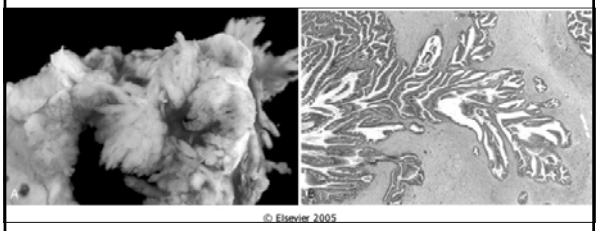


Figure 6-38
INTRADUCTAL PAPILLARY MUCINOUS NEOPLASM
Kaplan-Meier actuarial survival curves compare patients with surgically resected noninvasive and invasive IPMNs. (Fig. 5 from Sohn TA, Yeo CJ, Cameron JL, et al. Intraductal papillary mucinous neoplasms of the pancreas: an updated experience. Ann Surg 2004;239:793.)

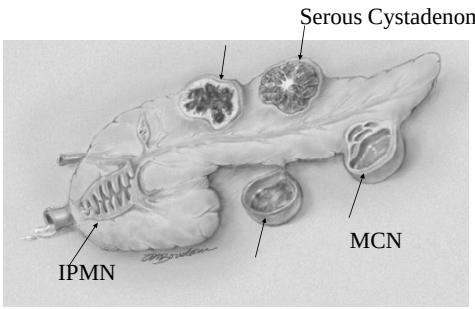
Intraductal papillary mucinous neoplasm (IPMN)



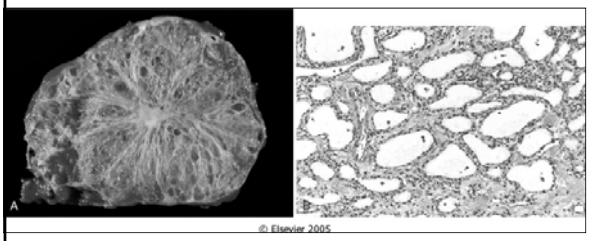
Associated with the pancreatic duct

Clinical spectrum: benign to malignant

PANCREATIC CYSTIC LESIONS

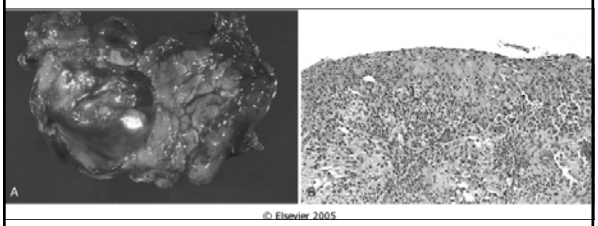


Pancreatic serous cystadenoma



BENIGN

Pancreatic Pseudocyst



NOT NEOPLASTIC - RESULT OF ACUTE PANCREATITIS

Serous Cystadenoma

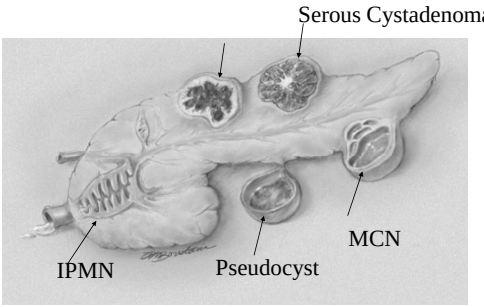
- Aka microcystic adenoma, glycogen rich adenoma
- F/M =7/1; mean age 66y
- Association with von Hippel Lindau syndrome
- Symptoms: none, local pain, obstruction if in head
- Clinical behavior: benign
- Gross: mean 11 cm; multiloculated mass, cysts filled with clear fluid; spongy; often central scar.
- Micro: small cystic spaces lined with cuboidal cells with clear cytoplasm (glycogen rich); round nuclei; some cases papillary.

Pseudocyst

- Localized collections of pancreatic secretions that follow pancreatitis, trauma, ductal calculi.
- Symptoms: Painful, Hemorrhage, Infection, Perforation
- Treatment: excise small pseudocysts in body/tail; drain cysts in head.

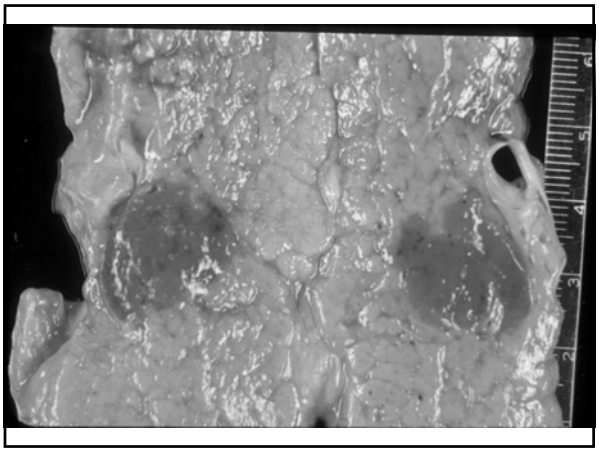
- Gross: 85% solitary, usually unilocular in/near pancreas; thick irregular wall, ragged inner surface.
- Micro: No epithelial lining, fluid has high amylase
- Cyst arises from drainage of pancreatic secretions from damaged ducts into interstitial tissue; wall consists of fibrous tissue/granulation tissue.

PANCREATIC CYSTIC LESIONS



Pancreatic Endocrine Neoplasms

- 5% of pancreatic neoplasms
- “Islet cell Tumors” – inaccurate; arise from pluripotential ductal cells that differentiate along neuroendocrine lines.
- All have malignant potential except microadenomas (<5mm); No definite criteria to distinguish between benign and malignant (except for mets)



Pancreatic Endocrine Neoplasms Microscopic

Nests of uniform polygonal cells

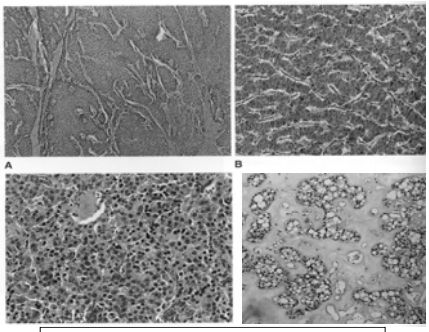
Delicate vasculature

Salt and Pepper (stippled) chromatin.

Often (no necrosis, low mitotic activity)

Immunostains do not correlate with secretion.

(Other than chromogranin and synaptophysin; **specific stains: glucagon, insulin, PP, VIP, ACTH, somatostatin not really useful**.)



Pancreatic Endocrine Tumors

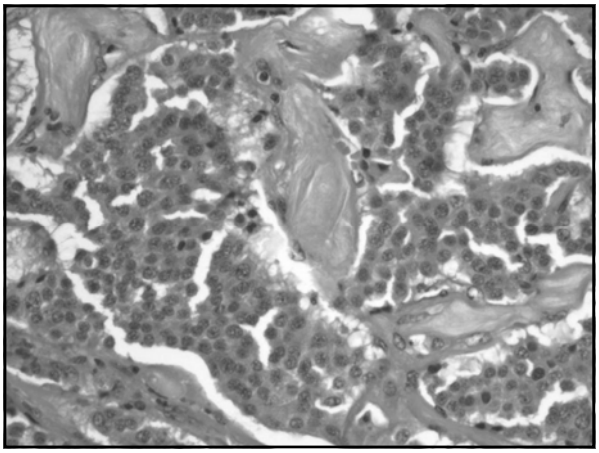
Pancreatic Endocrine Neoplasms

Functional - recognizable syndrome; detect hormone in serum.

- Insulinoma (most common); hypoglycemia; 10% malignant
  - 10% assoc with MEN1
- Gastrinoma; duodenal ulcers; 75% malignant
  - 25% assoc with MEN1

Nonfunctional - no syndrome; normal serum hormone levels (except Pancreatic Polypeptide).

- Incidental; Obstructive Sx- head of pancreas; 50 – 90% malignant.



Pancreatic Endocrine Neoplasms

- Usually occur in body/tail
- Hypervascular, circumscribed
- Highlighted with Octreotide Scan (somatostatin receptors)
- Usually slow growing, mets to LNs, liver, bone (recommend resection of mets)

Pancreatic Endocrine Neoplasms

Classification:

Neuroendocrine neoplasm, well differentiated

- Low grade: 0-1 mit/50HPF; no necrosis
- Intermediate grade: > 2mit/50 HPF; +/- necrosis

Neuroendocrine carcinoma, high grade

Small cell carcinoma / large cell neuroendocrine

- High grade: >10mit/10 HPF; widespread necrosis