Carcinoma head of pancreas is a disease with grave prognosis and the only curative treatment is surgery. Pancreatic lesions as autoimmune pancreatitis and interstitial pancreatitis are close mimics of the lesion. The concept of autoimmune pancreatic disease is a recent term in the last two decades, about the characteristic presentations of this disease [1-4]. However, definitive diagnosis is always a challenge [5-11]. The autoimmune pancreatitis and pancreatic adenocarcinoma may coexist and differentiating acute interstitial pancreatitis from autoimmune pancreatitis is not always easy [12-16]. The dual-phase contrast-enhanced MDCT remains the first line imaging modality in differentiating carcinoma pancreas and its close mimics. Material and methods: The study was a retrospective study of 93 patients were evaluated, including 40 patients with autoimmune pancreatitis, 26 patients with pancreatic adenocarcinoma, and 27 patients with acute interstitial pancreatitis, their imaging and the differentiating features were studied statistically with the help of Pearson’s chi-squared test. Result: The most common findings associated with autoimmune pancreatitis was diffuse involvement while in carcinoma pancreas it was focal involvement and in acute interstitial pancreatitis was peripancreatic fat stranding. Conclusion: The study highlights the significant positive findings on the multidetector CECT for an early diagnosis and early management if the pancreatic lesions. This helps in reduction of the chances of unnecessary surgical management and thus reduces the time of management and mortality in the patients.

**KEYWORDS**: Multidetector CT scan, Fat stranding, Dilated ducts
Results
A total of 93 patients were evaluated, including 40 patients with autoimmune pancreatitis,
26 patients with pancreatic adenocarcinoma, and 27 patients with acute interstitial pancreatitis. There was no significant difference in patient age ($p = 0.13$) or sex ($p = 0.85$) across the three cohorts.

MDCT Imaging Features
The most common imaging features among the 40 patients with autoimmune pancreatitis were diffuse involvement (figure 1) (26/40 [65%]), sausage shape (26/40 [65%]), low-attenuation halo (24/40 [60%]), vascular involvement (17/40 [42%]), and biliary wall enhancement (14/40 [35%]).

The most frequent imaging features among the 26 patients with pancreatic adenocarcinoma were focal involvement (figure 2) (25/26 [96%]), pancreatic duct dilatation (21/26 [80%]), biliary dilatation (11/26 [42%]), and vascular involvement (10/26 [38%]) with PPVs of 52%, 64%, 43%, and 28%. Pancreatic duct dilatation had the highest PPV for the diagnosis of pancreatic adenocarcinoma. The most frequent imaging features among the 27 patients with acute interstitial pancreatitis were diffuse involvement (19/27 [70%]) and peripancreatic stranding (23/27 [85%]) with PPVs of 42% and 55%. Peripancreatic stranding had the highest PPV for the diagnosis of acute interstitial pancreatitis.

Discussion
Autoimmune pancreatitis is usually diagnosed on the basis of a combination of clinical, serologic, radiological, and histological findings however, differentiating the relatively rare autoimmune pancreatitis from more common pancreatic diseases, such as pancreatic adenocarcinoma and acute interstitial pancreatitis, can be difficult, especially when clinical features overlap. Focal mass like enlargement and mild peripancreatic stranding, may also be seen in autoimmune pancreatitis and hence atypical for the diagnosis.

MDCT of Pancreatitis and Cancer
Focal pancreatic involvement was non specific as it was also common in the patients with acute interstitial pancreatitis. With the better recognition of atypical imaging features of autoimmune pancreatitis, the chances of patients with autoimmune pancreatitis undergoing surgical resection has reduced. However due to overlap of the radiological features, it is not always possible to correctly diagnose autoimmune pancreatitis on imaging alone. Several publications [12–14] have identified cases in which autoimmune pancreatitis and pancreatic ductal adenocarcinoma were diagnosed concurrently or in which pancreatic adenocarcinoma was diagnosed in patients having known history of autoimmune pancreatitis years after the initial workup.

Therefor these findings suggest that regular follow up is as prudent in autoimmune pancreatitis as it is in chronic pancreatitis. As in our findings, the presence of peripancreatic stranding was predictive of acute interstitial pancreatitis. Graziani et al also evaluated the relative enhancement rates of each diagnosis and observed that autoimmune pancreatitis had delayed enhancement compared with acute interstitial pancreatitis. The use of multiphasic pancreatic MDCT for quantifying enhancement across the unenhanced, pancreatic, portal venous, and delayed phases to differentiate autoimmune pancreatitis from acute interstitial pancreatitis is promising but has risk of increase radiation dose. This study had several limitations. Its retrospective design may have contributed in selection bias.

Accordingly our study may not be applicable to the general Indian population. Even our sample size was still small owing to the overall low prevalence of autoimmune pancreatitis. In addition, we did not further differentiate the two subtypes of autoimmune pancreatitis (types 1 and 2).

Inspite of all limitation the study focuses for pinpointing the respectable versus non respectable pancreatic conditions and helps in
reduction of number of the un-necessary surgical manipulation in unwanted cases thus reduced the mortality of the patient along with diverting the attention of surgeon toward the more demanding patients where surgical management is obligatory.

References