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Pancreatic tail tumour in a 56 year old female – a case report

Dr. Arkaprovo Roy	Assistant Professor, Department Of Surgery. Malda Medical College
Dr. Shreya Lahiri	Assistant Professor, Department of Anaesthesiology, Malda Medical College
Dr. Arup Kundu	Internee, Malda Medical College
Dr. Aishwarya Bhattacharya	Internee, Malda Medical College
Dr. Sadia Nazneen	Internee, Malda Medical College

ABSTRACT There are many different types of tumors that can develop in the pancreas. Approximately 85% patients have very aggressive type of tumor called adenocarcinoma of the pancreas. In about 15% of patients other tumors in the pancreas are found that are less aggressive types of tumors which are often curable. An evaluation in a center that is experienced in the treatment of pancreatic cancer is important for determining appropriate treatment for pancreatic tumors. Patients with tumors in the body and tail of the pancreas generally present with nonspecific pain and weight loss. Body and tail tumors are much less likely to cause obstructive signs and symptoms. Here we are going to discuss a case of pancreatic tail tumour in a 56 year old female patient. Patients with tumors in the body and tail of the pancreas generally present with nonspecific pain and weight loss. Body and tail tumors are much less likely to cause obstructive signs and symptoms. Here we are going to discuss a case of pancreatic tail tumour in a 56 year old female patient.

KEYWORDS : Pancreatic tail; Tumour; Enucleation.

Introduction:
The pancreas is a complex organ with many different types of cells in it. Each of these cell types may give rise to different types of tumors. The correct diagnosis of the tumor type is important since the prognosis for survival is dependant on the tumor type and surgical removal of some tumors in the pancreas can be associated with a normal life span. Often the type of tumor that is present in the pancreas can be diagnosed from specialized studies such as radioisotope studies and CT scans.

Tumours originating from the pancreatic body and tail are less in number than originating from head.

Surgical resection is the only potentially curative treatment for patients with pancreatic cancer, although many patients are not candidates for resection.

Case report:
A 56 year old female came to Surgery OPD with pain in the lower abdomen and difficulty in micturition. She is post menopausal, having three children and without any history of previous operation. On examination patient was pale and malnourished. Her blood pressure was 100/68 mm of Hg and pulse was 66/ minute. There was a lump in the left lumbar region extending to pelvis. The lump was variegated, firm to hard, mobile side to side and approximately 8cm x12 cm in size.

Patient was admitted for further investigation.
Laboratory findings were as follow:

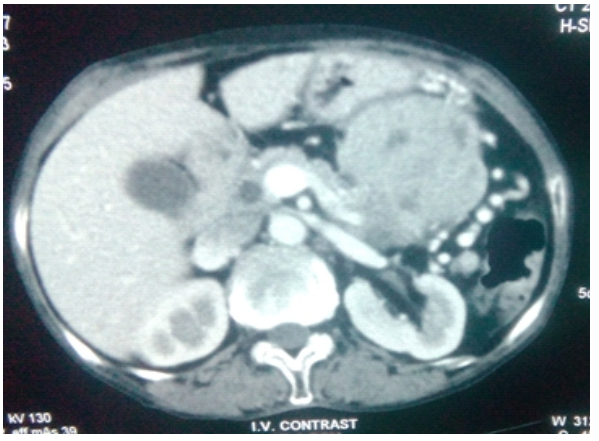
Haemoglobin: 9gm/dl. WBC-6,800/cumm. Neutrophil – 70%.

Sugar(random): 78gm/dl. Urea: 17 gm/dl. Creatinine: 0.6 gm/dl.

Liver function test and coagulation profile – within normal limit.

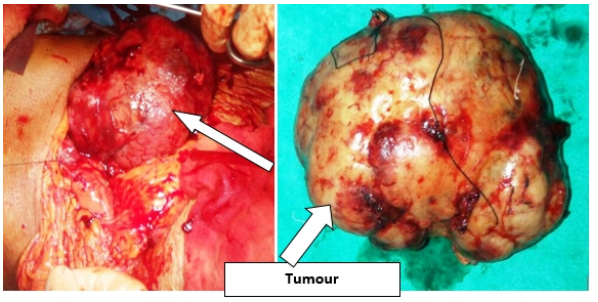
Chest X - ray and ECG – Normal study.

CECT abdomen shows: A swelling in the left lumbar region probably originating from pancreatic tail.



Arrow showing the tumour

After preanaesthetic check up we went for exploratory laparotomy and opened the lesser sac. We found a vascular fleshy firm 12cmx15cm mass originating from the tail region of the pancreas. We mobilize the left colon and took control of splenic vein. Then we took out the mass from tail of the pancreas without doning distal pancreatectomy or splenectomy.



Discussion:
Adenocarcinoma of the body and tail of the pancreas is treated with a distal pancreatectomy and splenectomy. Tumors of the body and tail of the pancreas are often more aggressive that the tumors of the head of the pancreas and have often undergone metastatic spread

to other organs at the time diagnosis. Surgery is only indicated in those patients in whom there is no evidence of metastatic spread. Surgery is often not possible in cancers of the body and tail of the pancreas if the tumor invades a blood vessel called the celiac artery.

Patients in whom the tumor is localized to the body and tail of the pancreas without invasion of the celiac artery and where there no evidence of metastatic spread to other organs should be candidates for surgery. The extent of the removal of the pancreas in the distal pancreatectomy depends on the location of the pancreas since an at least a half a centimeter of normal pancreas beyond visible tumor has to be removed with the cancer to ensure that all the cancer is removed. The surgeon should obtain a pathological evaluation of the cut end of the pancreas at the time of the surgery to ensure that there is no more tumor left behind in the pancreas during surgery.

All patients who undergo distal pancreatectomy and splenectomy for adenocarcinoma of the pancreas should receive chemotherapy and radiation therapy after recovery from surgery (1).

Pancreatic resections are complex operations that result in a high incidence of postoperative complications,including pancreatic endocrine and exocrine insufficiency.

Parencyhma-preserving procedures such as enucleation .have the potential to decrease the complications associated with anastomoses and decrease the rate of pancreatic insufficiency. Enucleations have been performed for smallbenign or premalignant lesions such as cystic tumors, neuroendocrine tumors and IPMN. Cauley et al described 45 consecutive patients who underwent pancreatic enucleation and compared them to a matched cohort of 90 patients who had undergone formal resection (2).

The largest study by Zhao et al.was published in 2011 and included 30 patients who underwent laparoscopic enucleation. Their study included 292 patients who underwent surgical treatment of insulinoma. The majority of patients underwent enucleation; 199 patients underwent open enucleation and 30 patients underwent attempted laparoscopic enucleation. The study reported no difference in blood loss, operative times, complications or lengths of stay between the open and laparoscopic group, but unfortunately their groups also included patients who underwent procedures other than enucleation, so definitive conclusions regarding laparoscopic versus open enucleation cannot be made (3).

The only other study reporting a comparison between laparoscopic and open enucleation was a small study published in 2009 by Karaliotas et al,who retrospectively reviewed the charts for seven patients undergoing open enucleation for insulinoma and five patients undergoing laparoscopic enucleation for insulinoma (4).

A pancreatic enucleation procedure is an operation designed to remove small, well-defined tumors of the pancreas. This procedure involves "shelling out" the tumor from the surrounding pancreas. A drain is often left over the area of the pancreas where the tumor was removed. Depending on the location of the tumor, the operation can sometimes be performed laparoscopically.

This approach differs from a pancreatic resection procedure (e.g., Whipple procedure, distal pancreatectomy, central pancreatectomy), which involves division and removal of a portion of the surrounding pancreas and tumor (5).

Pancreatic tumor enucleations can be carried out with good results and no mortality. Decisions regarding enucleations are highly individual compared to standard resections, underlining the importance of treatment in experienced high-volume institutions. Enucleations should be carried out whenever possible and oncologically feasible to prevent the typical complications of major pancreatic resection (6).

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