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PANCREATIC MUCINOUS CYSTADENOCARCINOMA PRESENTING AS A PANCREATIC PSEUDO-CYST

General Surgery

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ABSTRACT

Pseudocysts of the pancreas are the commonest form of cystic lesions that often develop in patients of chronic pancreatitis and less commonly, in patients of acute pancreatitis. However, neoplastic cysts are not as common as pseudocysts and only 15% of the pancreatic cysts are neoplastic, benign, or malignant[1]. Pancreatic cystic neoplasms can present as pseudo pancreatic cysts. The differentiation amongst the two is vital as principles of management of both the diseases are different.We present a rare case of a patient being misdiagnosed as pseuo pancreatic cyst but later on found to be a case of mucinous cystadenocarcinoma of body and tail.

KEYWORDS

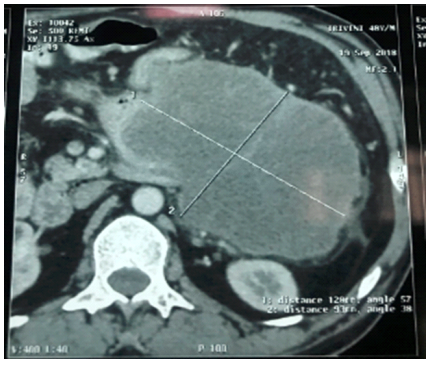
Pseudocyst, cystadenocarcinoma

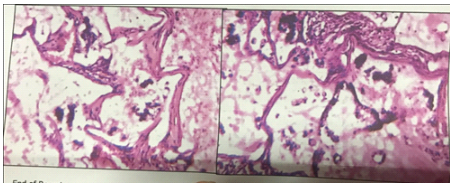
INTRODUCTION

Pseudocysts of the pancreas are the commonest form of cystic lesions that often develop in patients of chronic pancreatitis and less commonly, in patients of acute pancreatitis. However, neoplastic cysts are not as common as pseudocysts and only 15% of the pancreatic cysts are neoplastic, benign, or malignant(1). Pancreatic cystic neoplasms can present as pseudo pancreatic cysts. The differentiation amongst the two entities is vital as principles of management of both the diseases are totally different. We present a rare case of a patient being misdiagnosed as pseudo pancreatic cyst but later on found to be a case of mucinous cystadenocarcinoma of body and tail.

CASE REPORT

A 40 year old male was admitted to the surgery department of S. N. Medical College, Agra with chief complaints of swelling in abdomen especially left upper quadrant associated with vomiting and pain for 1.5 months. Patient also gave past history of multiple similar episodes of pain and vomiting for which he did not take any specific treatment. On clinical examination, a 12*10 cm sized firm to hard non-tender lump was palpable in the left upper quadrant. Rest of per abdominal examination was within normal limits. USG abdomen and CECT abdomen reports revealed a large 15.5*9.2 cm sized non-enhancing hypodense lesion in close approximation to the posterior aspect of pancreatic tail , markedly Indenting and compressing the tail with extension to lesser sac and adjoining mesentry in left hypochondrium and lumbar region, likely suggestive of pseudo pancreatic cyst. Hematologically, patient was stable, Hb- 11.4, TLC- 7800 cells/cu.mm , LFTs and RFTs were within normal limits. Serum amylase levels were also within normal limits. However, the patient's history was complying with the radiological reporting but the clinical findings(firm to hard palpable lump, normal amylase) were not. The patient was taken up for an exploratory laparotomy. Intra-operatively, a huge (approx 20*20*10cm) solid mass was found arising from the pancreatic body and tail and was adhered to proximal jejunum and transverse colon. Debulking of the tumor was done along with resection and anastomosis at both the jejunic and colonic sites. The histo-pathological examination of the debulked tissue revealed well differentiated mucin secreting adenocarcinoma.





DISCUSSION

This case report shows similar presentations of pancreatic pseudocyst and mucin secreting adenocarcinoma of the pancreas. Similar clinical presentation and misleading radiological findings can often lead to wrong interventions and hazardous consequences in the patients. Cystic tumors of the pancreas account for 15% of all pancreatic cysts but only 1% of all pancreatic malignancies and predominantly appears in the body or tail of the pancreas, although occasionally, may occur in the head[1,2]. Pancreatic pseudocysts comprise 75% of cystic lesions of pancreas; 5–10% of patients with acute pancreatitis and up to 50% of patients with chronic pancreatitis may develop pancreatic pseudocyst [3]. Patients may present with epigastric pain, palpable abdominal mass, nausea, vomiting, diarrhea, steatorrhea, and/or weight loss[2]. Imaging with computed tomography scan (CT) and magnetic resonance imaging (MRI) can be useful to differentiate pancreatic cystic neoplasm from pseudocyst. Presence of multiple cysts and internal septations are highly suggestive of tumor[2,4].

Besides imaging, CEA is a highly sensitive tumor marker to differentiate between mucinous and nonmucinous cyst. Cyst fluid amylase level is elevated in approximately 50–75% of the patients of pancreatic pseudocysts, with pseudocyst being effectively ruled out if amylase level is below 250 U/L[4]. Biopsy of the cyst wall with frozen section examination should always be performed to differentiate pseudocyst from cystic neoplasms[3,4] .

In a large series of patients with resectable mucinous cystadenocarcinoma of the pancreas, a 5−year survival of 63% was reported[5] . In another similar study, 62% of the patients had no disease recurrence after a mean follow−up of 61 months [6]. Hence, survival following surgical

resection was better as compared to non-resected patients with mucinous cystadenocarcinoma[7].

In our case, the patient had episodes of recurrent nausea and vomiting for a few months prior to his presentation. The chronic history of nausea, vomiting, abdominal pain was followed by the development of an abdominal mass. The clinical presentation when combined with the ultrasonography and contrast computed tomography findings supported the diagnosis of pancreatic pseudocyst that most probably developed on the background of chronic pancreatitis.

The diagnosis of pancreatic neoplasm should always be kept in mind while dealing with patients with the probable diagnosis of pseudo pancreatic cysts, as, if neoplasms are managed by drainage procedures, internal or external (which is done for pseudocysts), it will not only cause persistent or aggravated symptoms but also can convert a potentially curable malignancy to an incurable one by aiding distant/peritoneal metastasis.

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