ORIGINAL RESEARCH PAPER

General Surgery

KEY WORDS: pancreatic cyst, mucinous cystic neoplasm

A RARE PRESENTATION OF PANCREATIC CYST

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ABSTRACT

Mucinous cystic neoplasms (MCN) of the pancreas are rare tumors, constituting 2–5% of pancreatic neoplasms, that are found almost exclusively in perimenopausal women as single lesions in the body and tail of the pancreas with no connection to the ductal system. We report a case Susheela 42/F with complaints of Epigastric fullness for 2weeks and Abdominal pain for 1week and Fever for 3 days.Fullness present over epigastric and left hypochondrium.15*12cm swelling present over left hypochondrium left epigastric region.Margins well defined.Firm in consistency.

INTRODUCTION:

Mucinous cystic neoplasm (MCN) of the pancreas is a rare mucin-producing cystic neoplasm that has a characteristic histological feature referred to as ovarian-type stroma (OS) underlying the epithelium. Pancreatic ductal carcinoma arises from MCN as a precursor lesion, but data on progression pathways are limited. ntroduction Mucinous cystic neoplasms (MCNs) have been defined as large, separated, thick-walled cysts without connection to the pancreas duct system.1 Based on the WHO criteria in 1996, the study for 130 cases of MCN with ovarian type stroma (OS) indicated to be female patients appearances in whole cases and body/tail location in almost.2 Therefore, as a rough rule for pancreas cystic neoplasms, in male and in the head of the pancreas are likely to be IPMNs, whereas cyctic lesions in the body/tail in female may be either an MCN orIPMN.3 And, in the past several years, mucinous cystic neoplasms of the pancreas have been diagnosed more and more frequently

Case report:

History : Susheela 42/F admitted with the complaints of Fever x 3 days Abdominal pain x 1week Epigastric and left upper quadrant fullness x 2weeksNo h/o vomiting/loss of apettite /loss of weight No h/o hametemesis/ malena/ obstipation. No h/o loose stools, hematochezia No h/o previous attacks of abdominal pain H/o PS done 15 yrs back.

Clinical examination:

General examination of the patient was within normal limits.

On local examination, Abdomen distended. All quadrants moves equally with respiration. Flanks full. No scar, no sinus. No VGP /VIPHernial orifices normal. External genetalia normal. on palpation Abdomen soft. Not warmth No tenderness. Fullness present over epigastric and left hypochondrium. 15*12cm swelling present over left hypochondrium and left epigastric region. Margins well defined.Firm in consistency. Surface smooth. swelling does not moves with respiration

INVESTIGATIONS

- SGOT,SGPT –NORMAL
- SERUM AMYLASE- 126IU/L
- LIPASE -138IU/L.

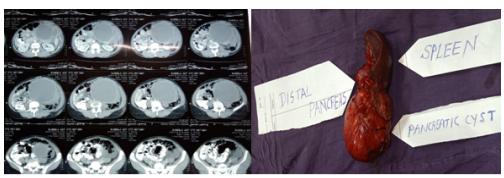
- **USG finding:** Large 13*11cm heteroechoic lesion involving left hypochondrium and left lumbar region.
- Free fluid present.
- IMP:? Mesentric cyst

CECT ABDOMEN

Well defined hypodense lesion 10*13*11 cm with peripheral enhancing wall with surrounding extensive fat stranding with multiple small cysts communicating to the bigger lesion. Lobulated appearance of the cyst. Free fluid in abdomen. Imp: focal pancreatitis with acute necrotic collection.

TUMOUR MARKERS:

- CEA -300ng/ml
- CA19-9 >12000u/l



Surgical intervention findings:

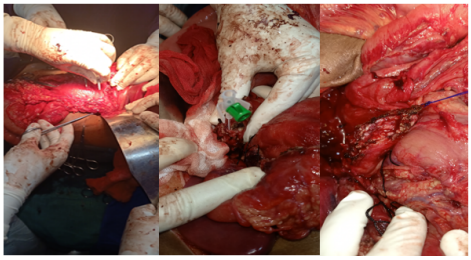
UGI scopy done suggest normal study upto D2.

Hence we diagnosed as Cystic Neoplasm of Pancreas and planned for exploratory laparotomy.

Intaoperative findings:

- 15*15 sized cystic lesion occupying lesser sac adherent to the parietal peritoneum, posterior wall of stomach, spleen and transverse colon is present.
- Meticulous separation of the cyst was done.
- Accidentally cyst wall ruptured and 500ml of purulent fluid drained out.

Cystic lesion arising from the tail of the pancreas.



PROCEDURE DONE:

- **Distal Pancreatectomy With Splenectomy And Enblock Resection OfThe CYST.**
- Patient had uneventful postoperative period and Drain was minimal.suture was removed on 10 th POD.

Post op tumor markers:

- CEA-6ng/ml
- CA19-9-250IU/ml

BIOPSY REPORT:

- mucinous cystic neoplasm with low grade dysplasia

PUS C/S- No growth Post-operative period was uneventful. Patient was discharged on seventh postop day after regaining normal bowel and bladder habits and advised follow-up after 5days for suture removal.

Follow up:

Follow up of patient after 5days revealed a healthy wound and patient was asymptomatic.

After 5 months follow up, patient was found to have healed scar with no evidence of recurrences.

DISCUSSION

Mucin-producing cystic neoplasms of the pancreas have developed a well-recognized entity. In the two decades, due to the utility of high-resolution abdominal imaging techniques, similar cystic lesions of the pancreas are increasingly identified incidentally,4 and a large number of patients have undergone surgical resection.5 In 1996, under the aim to describe and categorize the cystic lesions of the pancreas, the WHO classification defined MCN as cystic epithelial neoplasms composed of columnar, mucin-producing epithelium, supported by OS.6 The OS is known for forming a band of densely packed spindle cells beneath the epithelium; its presence has become a critical requirement as MCN. Then, the MCN was estimated for the different concept from IPMN in the past categories for cystic lesion. And, the Armed Forces Institute of Pathology (AFIP) classification also added the finding for no communication with the pancreas ductal system.7 Taken together, no doubt to diagnose the present cystic lesion as MCN was detected. Although the developmental process of MCN has not been well understood, it is indicated to originate from remnant primordial gonadal cells that migrated to the pancreas, because the left primordial gonad and dorsal pancreas anlage lie side by side during embryogenesis.8 The dorsal anlage develops the body and tail of the pancreas; therefore the MCN was frequently raised in the dorsal pancreas and detected in female. Indeed, from the past reports for 130 cases2 and 56 cases8 with MCN, no male case has been demonstrated.

By contrast, the present MCN was found to have neither estrogen nor progesterone receptors. These rare patterns become the originality of MCNs to be unclear, and then further investigations should be continued.

CONCLUSION :

Mucinous nonneoplastic cyst of the pancreas is generally benign and requires little follow-up, but large cysts may penetrate other organs and cause severe complications. Mucinous nonneoplastic cyst of the pancreas is a rare disease defined as a cystic lesion lined with mucinous epithelium, supported by hypocellular stroma and not communicating with the pancreatic ducts. Mucinous nonneoplastic cyst of the pancreas has no malignant potential and does not require surgical resection or surveillance

Conflict of interest: No

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