and a fistulous communication with the distal ileum. The ileo-colic anastomosis was normal. The liver was normal and there was no evidence of any distant metastasis or ascites. In view of localized disease, a Whipple pancreaticoduodenectomy with extended pancreatic lymph nodal clearance and wide resection-anastomosis of the involved ileum were performed (Fig). Histology revealed moderately differentiated mucinous adenocarcinoma of the colon, all the resected margins and the lymph nodes being negative. At 4-month follow up, after chemotherapy (irinotecan 500 mg, 3-weekly for 3 cycles) and radiotherapy with 3000 rads to the tumor bed, CEA level was 2.2 ng/dl.

Discussion

In recent years, there has been a substantial decrease in in-hospital mortality and morbidity after pancreatic resection, with several series reporting mortality rates of less than 5%. With this, the indications for pancreaticoduodenectomy have expanded to include treatment of chronic pancreatitis, islet cell neoplasms and cystic lesions of the pancreas, and metastatic lesions to the peripancreatic region.5,6 Complete clearance of the tumor was associated with mean survival of 12 and 14 months in two series. Le Borgne et al9 reported a mean survival of 26 months. Curley et al10 reported pancreaticoduodenectomy for colonic tumors directly invading the duodenum or the pancreas and showed prolonged survival for these patients.

In general, metastasis from distant primaries to the pancreas is associated with widespread disease. However, in a select subgroup with metastasis to the peripancreatic region as the sole site of metastasis, resection may render the patients disease-free. These patients may achieve a significant survival period after resection. Most such metastatic tumors are node-negative in spite of their large size, as was observed in both our patients.

References


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