Spleen-preserving distal pancreatectomy following neoadjuvant chemotherapy for papillary solid and cystic neoplasm of pancreas

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Papillary solid and cystic neoplasm (PSCN) is a rare neoplasm of the pancreas with low-grade malignant potential and favorable prognosis. We report an 18-year-old girl with PSCN presenting with advanced disease. The tumor regressed with six cycles of gemcitabine and cisplatin-based neoadjuvant chemotherapy; spleen-preserving distal pancreatectomy was then done. She is disease-free at 13 months' follow-up. [Indian J Gastroenterol 2004;23:188-189]

Key words: Cisplatin, gemcitabine, pancreas tumor

Papillary solid and cystic neoplasm is a rare neoplasm of the pancreas, usually occurring in young patients. The main treatment is surgery: the role of chemotherapy and radiotherapy is not well defined. They generally have a favorable prognosis.

An 18-year-old girl presented with pain and mass in the abdomen for 6 months. On examination, all systems were within normal limits except for a huge mass in the left hypochondrium. Laboratory investigations were normal. CT scan (Fig) showed a large soft-tissue mass (10.9 cm x 6.8 cm) arising from the body and tail of the pancreas with multiple calcifications, a few areas of necrosis and cystic changes, with posterior gastric wall infiltration and para-aortic lymphadenopathy. Ultrasound-guided FNAC showed papillary neoplasm. Since the tumor appeared unresectable, she was started with gemcitabine and

References

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Cisplatin-based neoadjuvant chemotherapy (800 mg/m² and 30 mg/m² weekly, respectively). After completion of 6 cycles, the tumor regressed more than 50% as documented by a repeat CT scan (Fig).

On exploration, there was a 5.2 cm x 4.1 cm well-capsulated tumor occupying the distal part of the pancreas, without gastric involvement and lymphadenopathy; spleen-preserving distal pancreatectomy was performed. On cut section, the tumor had multiple cystic components and solid areas with necrosis and calcification. The patient had smooth postoperative recovery. Histology revealed a low-grade solid and cystic papillary carcinoma with extensive necrosis, fibrosis and dystrophic calcification. The patient is doing well 13 months later.

Papillary cystic tumor of the pancreas is typically an encapsulated solid mass with areas of necrosis and cyst formation. The average tumor is 10 cm in diameter; it is more frequent in the body and tail of the pancreas. It is benign or has low malignant potential with rare invasion of surrounding tissues and organs and metastasis. This is almost exclusively a disease of young women, and the commonest presentation is with abdominal discomfort or pain and a mass. The recommended treatment is complete surgical excision since curability is high and radio-chemotherapy is supposed to be of no use. Strauss et al. reported a 15-year-old girl who at laparotomy was found to have an unrespectable 15-cm tumor invading the superior mesenteric vein. It regressed when treated with cisplatin and 5-fluorouracil for 6 months, leaving a 3.5-cm mass that was then resected.

To our knowledge, there is no report about the use of neoadjuvant gemcitabine and cisplatin-based combination chemotherapy for the management of this tumor. Gemcitabine-based chemotherapy is used in the treatment of adenocarcinoma of the pancreas. We used neoadjuvant gemcitabine combined with cisplatin-based chemotherapy with good response, with more than 50% regression of the tumor and disappearance of para-aortic lymphadenopathy and posterior gastric wall infarction. We could then perform spleen-preserving distal pancreatectomy without multivisceral resection.

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Diaphragm disease of duodenum following long-term NSAIDs use: endoscopic management

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We report our experience with endoscopic management of 3 men (aged 62, 63 and 65 years) with duodenal diaphragm disease following NSAID use for 5-15 years. In the first patient a 24 F through-the-scope balloon dilation was attempted but failed; he subsequently underwent gastro-jejunostomy. The other two patients subsequently underwent radial incisions of the web with mixed cutting and coagulation current using a standard 5 F sphincterotome. (Indian J Gastroenterol 2004;23:189-190)

Key words: Diaphragm disease, small bowel

Lang et al. were the first to report diaphragm-like ileal strictures in 7 patients taking non-steroidal anti-inflammatory drugs (NSAIDs) for prolonged periods. Subsequently several reports confirmed the relation of these lesions in the ileum, jejunum and even colon to the use of NSAIDs. Anecdotal case reports documented the presence of similar lesions in the duodenum. Duodenal webs, unlike the ileal lesions for which surgery is the only option, may be amenable to endoscopic therapy. This is important as most of these patients are elderly and have associated co-morbid diseases. We have previously reported our success in incising multiple duodenal webs using a sphincterotome.

Case 1: A 65-year-old man with rheumatoid arthritis for the last 15 years presented with complaint of post-prandial abdominal distension of 3 weeks’ duration. He had intermittent large-volume vomiting, which relieved the distension. Physical examination showed typical deformities suggestive of chronic rheumatoid arthritis. A loud succussion splash was elicited over the epigastric region. Endoscopy revealed a post-bulbar smooth concentric structure in the second part of the duodenum. This was also demonstrated on barium meal study of the stomach. Dilation was attempted using a 24 F through-the-scope dilatation balloon (Max force; Boston Scientific, USA). There was a minor increase in the lumen of the web but the patient continued to be symptomatic and was therefore taken up for gastro-jejunostomy.