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Gastrointestinal

Pancreatocolonic fistulization secondary to pancreatic adenocarcinoma presenting as unexplained halitosis

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ABSTRACT

Pancreatic cancer is often detected in late stages, which contributes to its grim prognosis. Although the manifestations of pancreatic cancer most often include nonspecific gastrointestinal complaints, we report a case with the sole initial complaint of halitosis and subsequent diagnostic workup demonstrating a pancreatic mass with secondary pancreatocolonic fistulization. The etiologies of and the radiological findings pertaining to halitosis, the presenting symptoms and imaging studies relevant to the diagnosis of pancreatic cancer, and the imaging and clinical findings of pancreatic fistulization are discussed.

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Case report

A 77-year-old man with a medical history of long-standing insulin-dependent diabetes mellitus presented to a gastroenterology clinic at the urging of his wife because of her perception that the patient had developed severe, feculent halitosis. This odor had not improved with oral hygiene and dental consultation had not been helpful. The patient noted slight unintentional weight loss over the past 3 months but was otherwise asymptomatic. The patient had a prior episode of reportedly idiopathic acute pancreatitis 7 years previously.

Laboratory testing demonstrated normal liver function test results. Amylase and lipase levels were both within normal limits. Fluoroscopic barium esophagography to investigate the possibility of a Zenker diverticulum demonstrated no luminal irregularities or dysmotility. Because of this history of unexplained pancreatitis and weight loss, computed axial tomography of the chest, abdomen, and pelvis was obtained, revealing an irregular, up to 8-cm pancreatic tail mass abutting the stomach and the transverse colon (Fig. 1).

Endoscopic ultrasonography (EUS) revealed an irregular, hypochoic mass with poorly defined borders and evidence of invasion into the small bowel, and fine needle aspiration of the

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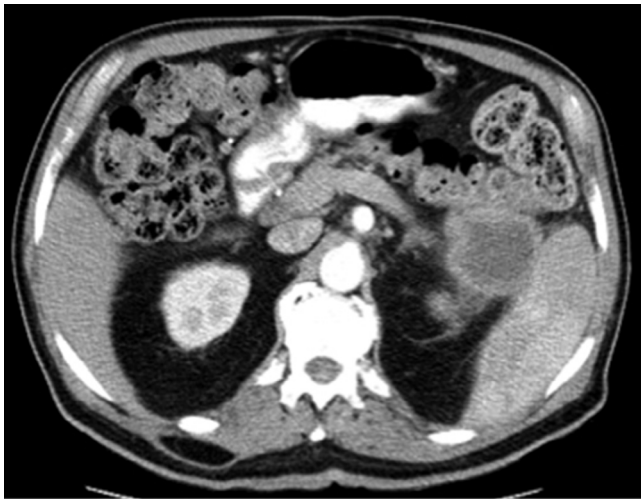


Fig. 1 – Axial and sagittal projections of the patient’s contrast-enhanced computed tomography of the abdomen demonstrate an approximately $7 \times 8 \times 7$ cm mass with central hypodensity arising from the tail of the pancreas. Fat planes between the mass and the stomach, the transverse colon, the spleen, and the left kidney are completely effaced. There is thickening of the walls of the stomach and the transverse colon immediately adjacent to the pancreatic mass.

pancreatic mass demonstrated adenocarcinoma. Fluorine-18 fluorodeoxyglucose positron emission tomography (18F-FDG PET/CT) was ordered for further characterization of the mass, initial staging, and to serve as a baseline to assess for response to treatment. 18F-FDG PET/CT demonstrated a large, peripherally hypermetabolic and centrally necrotic heterogeneous mass in the left upper abdominal quadrant centered in the tail of the pancreas and inseparable from multiple surrounding structures (Fig. 2). PET/CT did not demonstrate evidence of distant metastatic disease or occult lesions in the

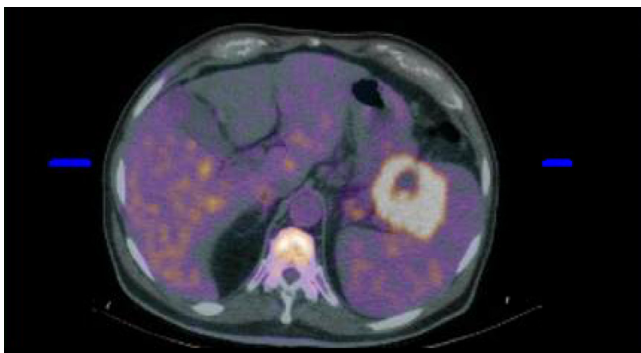


Fig. 2 – Axial fused Fluorine-18 fluorodeoxyglucose positron emission tomography computed tomography of the abdomen show intense peripheral hypermetabolic activity associated with the pancreatic mass, which is inseparable from the spleen and the proximal greater curvature of the stomach. The mass demonstrates central photopenia likely consistent with tumor necrosis.



Fig. 3 – Coronal computed tomography of the abdomen demonstrates a large, ill-defined hypodense mass centered in the region of the pancreatic tail with invasion into the wall of the greater curvature of the stomach, the spleen, and the left kidney. The boxed “A” indicates that this is anterior view from a multiplanar reformat.

liver or distant sites. The lack of distant metastases was one of the justifications for taking the patient to surgery.

After evaluation by medical and surgical oncology, the patient began chemotherapy with gemcitabine and abraxane, with subsequent tumor progression. The chemotherapy regimen was switched to a combination therapy utilizing fluorouracil, irinotecan, oxaliplatin, and folinic acid. After 6 cycles of FOLFIRINOX, CT demonstrated a decrease in size of the primary tumor and no new areas of disease.

Preoperative imaging after 6 months of neoadjuvant chemotherapy demonstrated an increase in the size of the mass with invasion of the posterior wall of the stomach, the colonic splenic flexure, the anterior aspect of the spleen, and the superior pole of the left kidney (Fig. 3). Additionally, there was a suggestion of fistulization with the transverse colon as evidenced by air within the mass (Fig. 4). The patient underwent exploratory laparotomy, partial gastrectomy, partial colectomy, partial omentectomy, distal pancreatectomy, splenectomy, left nephrectomy, and duodenal resection, with T3N1 disease staging. The presence of a pancreatocolonic fistula was confirmed during surgery. Two months postoperatively, the patient remains with good performance status. Halitosis resolved in the immediate postoperative period without recurrence.

Discussion

Pancreatic cancer is a diagnosis with grim 1 and 5-year survival rates [1]. It is generally believed that the poor prognosis

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