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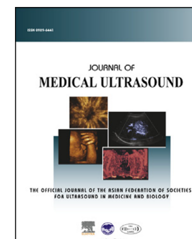

CASE REPORT

Pancreatic Sarcoma Mimicking Pseudocyst After Pancreatitis: A Case Report and Review of the Literature

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A 45-year-old female presented with abdominal pain for 3 days without trauma history. The pain was located over the epigastric area with radiation to the back. A pancreatic pseudocyst was impressed initially according to clinical symptoms, laboratory data, and image studies. However, rapid progression of the lesions was noted later after discharge. Following image studies showed circumscribed tumors in the head, body, and tail regions of the pancreas. Surgery with the Whipple operation was performed during the second admission. The post operation course was uneventful. Pathologic results showed sarcoma of the pancreas. Primary pancreatic sarcomas are extremely rare lesions accounting for < 0.1% of all pancreatic malignancies. Pancreatic sarcomas tend to be aggressive and have a poor prognosis. In addition, < 5% of pancreatic tumors are cystic. The rarest cystic neoplasm is also the primary pancreatic sarcoma, with only a few cases having been documented. However, it should be considered in the differential diagnosis of pancreatic cystic lesions.
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Introduction

Sarcomas represent a relatively rare malignant entity. Primary sarcomas of the pancreas are even rarer [1]. They comprise < 0.1% of malignant pancreatic neoplasms, with only a few cases previously documented in English literature [2]. Fewer than 5% of pancreatic tumors are cystic;

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microcystic cystadenoma, and macrocystic cystadenocarcinoma are the most common. The rarest cystic neoplasm is the primary pancreatic sarcoma [3]. These tend to be more aggressive and have a poor prognosis. We present a patient with such a rare condition with pancreatic sarcoma initially mimicking a pseudocyst.

Case report

A 45-year-old female suffered from epigastric pain with radiation to the back for several days. When she came to our outpatient department for help, elevated amylase and lipase levels were noted (476 U/L and 1239 U/L, respectively). She was then admitted to a ward in Cheng-Ching General Hospital, Taichung, Taiwan for further evaluation and management under the impression of acute pancreatitis.

After admission, an abdominal sonogram revealed: moderate fatty liver, a cystic lesion 2 cm in the pancreatic head, and another lesion ~2.2 cm in the body of the pancreas (see Fig. 1). Differential diagnosis included: pseudocyst, cystic tumor or hypoechoic tumor of pancreas. Computed tomography (CT) of the abdomen was done and it showed: two cystic lesions and two suspected pseudocysts in the pancreatic head and body. Tumor markers were as following: Carcino Embryonic Antigen (CEA) 0.77 ng/mL (< 5.0) and CA19-9 17.65 U/mL (< 37). After medical treatment, the abdominal pain improved gradually. She was discharged 5 days later. After discharge, she was followed regularly at our outpatient department. Unfortunately, an abdominal sonogram 2 months later showed increased sizes of previous pancreatic lesions. Abdominal CT followed and the results showed: four circumscribed tumors with irregular wall thickening 3.4 cm in the head, 3.2 cm and 3 cm in the body, and 1.2 cm in the tail region of pancreas. The patient was then admitted again for further evaluation and management.

The patient denied a history of systemic disease or major operations. She did not have a habit of cigarette smoking or alcohol drinking. No previous family history of malignancy was noted. After admission, the patient appeared ill looking. She was conscious, lucid, and cooperative. Vital signs were as follows: blood pressure 128/76 mmHg, pulse rate 88/minute, respiratory rate 18/minute, and temperature 36.2°C. Her sclera was not icteric and the conjunctiva was not pale. Chest examination showed clear breathing sounds over both lung fields. Observation of the heart showed a regular heartbeat without murmur.

Distension of the abdomen was present and mild abdominal tenderness over the epigastric area was noted.

Laboratory data showed that the white blood cell count was 7180 per microliter without left shifting of segment 70%, hematocrit 38.9% (34–44%), hemoglobin 13.2 g/dL (12–16 g/dL), sodium 138 mmol/L (135–148 mmol/L), potassium 3.6 mmol/L (3.5–5.0 mmol/L), blood urea nitrogen 8 mg/dL (7–20 mg/dL), creatinine 0.8 mg/dL (0.5–1.5 mg/dL), Aspartate Aminotransferase (AST) 19 U/L (5–40 U/L), Alanine Aminotransferase (ALT) 28 U/L (3–35 U/L), alkaline phosphatase 124 U/L (35–104 U/L), and total bilirubin 0.3 mg/dL (0.2–1.2 mg/dL). Tumor marker levels examined after admission including alpha-fetoprotein (AFP) 3.75 ng/mL (< 8.78), CEA 0.69 ng/mL (< 5.0), and CA19-9 9.32 U/mL (< 37) were within normal limits. The chest roentgenogram showed normal lung fields. The electrocardiogram showed normal sinus rhythm. On the 2nd day of admission, an operation was performed after discussion with the patient and her family. The Whipple operation was performed smoothly. Partial pancreatectomy, partial gastrectomy, and splenectomy were done (see Fig. 2).

The operative findings showed many endurated mass lesions locating over the pancreatic head with extension to neck, and body. The pathologic report showed sarcoma involved all of the pancreatic lesions and pancreatitis of the pancreas. The microscopic finding was: French Federation of Cancer Centers Sarcoma Group (FNCLCC) Grade II sarcoma composed of hyperchromatic spindle cell with mitosis (10-19/10HPF), pancreatitis with lymphocytic infiltration, focal fibrosis, and fat necrosis. Immunohistochemical stain: CD117 (−), smooth muscle actin (+), Cytokeratin (CK) (−), S100 (−), desmin (−), and vimentin (+). The post operation course was uneventful and she was discharged 15 days after the operation. Her condition remains stable after 12 months of follow up from the time she was discharged (see Fig. 3).

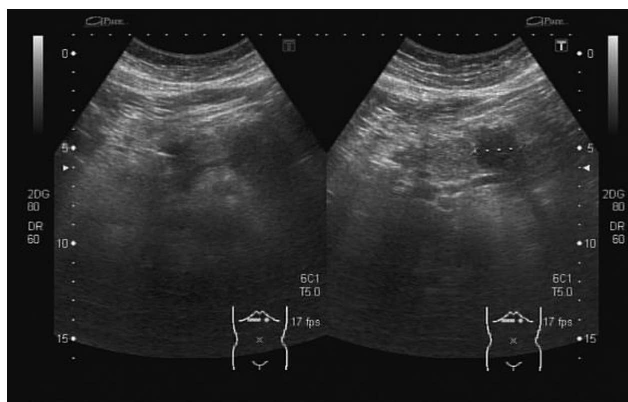

Fig. 1 Abdominal ultrasonogram during the first admission. The sonogram shows a cystic lesion 2 cm in the body of the pancreas.

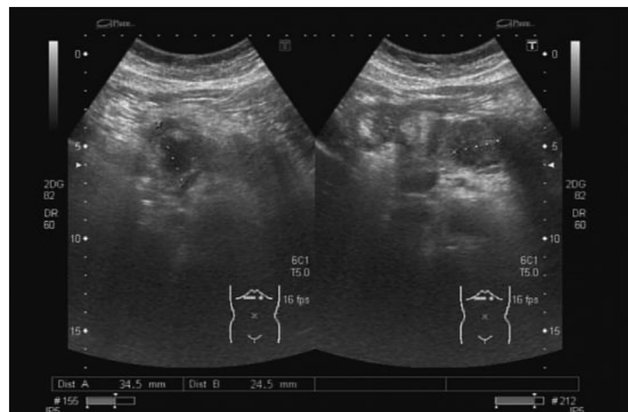

Fig. 2 Abdominal sonogram after the first admission. The sonogram shows increased sizes of cystic lesions with irregular wall thickening of the pancreas.

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