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A rare case report of Solid Pseudopapillary Tumor of the pancreas with portal hypertension

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ABSTRACT

INTRODUCTION: Solid Pseudopapillary Tumor of the pancreas (SPT) is a rare pancreatic tumor and represents 1–3% of all pancreatic tumors. It usually presents in young females with abdominal pain, nausea, vomiting and abdominal fullness. The first case report was documented in 1959 and since then multiple case reports have been documented on the various surgical approaches for SPT. However, there are not many reported cases where surgery has been performed on SPT with portal hypertension.

PRESENTATION OF CASE: In our case report, a 19 year old girl presented with a mass in the left side of the abdomen with associated dragging pain. Ultrasound Abdomen and CT (computed tomography) confirmed an SPT with portal hypertension, with the lesion involving the body and tail of pancreas.

DISCUSSION: Although few reports are available on SPT with portal hypertension, ours is the first report on a benign SPT with sinistral portal hypertension treated with a distal pancreatectomy. The presence of portal hypertension made the excision of the tumor and delineation of the vessels very difficult. However, when great care is taken while handling the dilated vessels, dissection can be completed with minimal blood loss.

CONCLUSION: Meticulous surgical technique along with accurate identification of vasculature will aid in the resection. Although some SPTs behave aggressively, most of them are benign and patients with SPT have an excellent prognosis.

1. Introduction

Solid Pseudopapillary Tumor of the pancreas (SPT) is a rare pancreatic tumor that usually presents in young females. Multiple studies have demonstrated the course and nature of this tumor. Various surgical approaches for SPT have been documented. However, not much has been written about the scope for surgery in an SPT with Portal Hypertension. We describe the possibility for resection of tumor and discuss the outcome in a 19 year old who presented with SPT with Portal Hypertension.

2. Presentation of case

A 19-year-old girl was admitted with complaints of fullness in the left side of the abdomen for the past month. She also complained of a dragging pain in the abdomen for the past week. There was no history of vomiting, constipation, fever or yellowish discoloration of eyes. Patient was otherwise asymptomatic.

On general examination vitals were stable, patient was well-built and well-nourished and general condition was fair.

On examination of the abdomen, a mass was palpable in the left hypochondrium extending into the epigastric region. The mass was 15 × 18 cm in size, non-tender and moving well with respiration. All borders except the superior border were well made out. No other mass was palpable in the abdomen.

Ultrasound abdomen showed moderate splenomegaly with a heterogeneous lesion involving the body and tail of the pancreas. CECT (Contrast enhanced Computed Tomography) (Fig. 1) abdomen revealed a huge heterogeneous mass lesion replacing the body and tail of pancreas with extension mass effect indicative of a Solid Pseudopapillary Tumor of the pancreas with left sided portal hypertension. Gastric varices were made out on upper GI (Gastrointestinal) endoscopy. The cause of the left sided portal hypertension was due to the compression caused by the large pancreatic tumor on the splenic vein leading to splenic vein thrombosis. Reconstruction of the vessels was done to study the vascular anatomy.

After a preanaesthetic work up, patient was taken up for surgery. Patient underwent an exploratory laparotomy and a 16 × 10 cm lesion involving the body and tail of pancreas (Fig. 2) was noted

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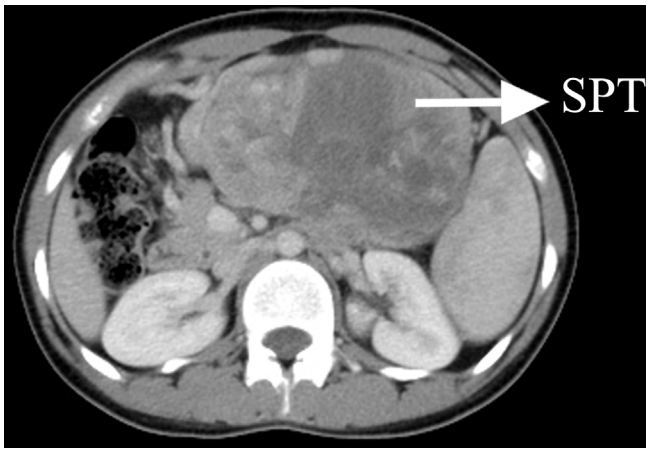

Fig. 1. CECT Abdomen showing a heterogeneous mass lesion replacing the neck, body and tail of pancreas.

along with dilated and tortuous gastric and splenic vasculature (Fig. 3). Excision of the tumor was done which required a distal pancreatectomy and this was combined with a splenectomy (Fig. 4). Spleen preserving pancreatectomy was not attempted in view of the varices, as the splenectomy also acts as a treatment modality for the varices. Post-operative vaccinations and antibiotics were given. Oral feeds were started on day 3 and sutures removed on day 13. Final histopathology report confirmed an SPT and tumor board discussion reassured that no chemotherapy was needed. Patient was reviewed after 1 month, 3 months and 1 year and continues to do well. Upper GI endoscopy and ultrasound of the abdomen were done at the 3 month follow up which showed no gastric varices or signs of portal hypertension.

3. Discussion

SPT represents 1–3% of all pancreatic tumors [1]. It usually presents in young females with abdominal pain, nausea, vomiting, and abdominal fullness [2]. The first case report was published in 1959 by Frantz [3] and since then multiple case reports and studies have been documented on both laparoscopic and open surgical options for SPT. However, not many case reports have been documented where surgery has been performed on cases with sinistral portal hypertension. One case report by Wani et al. describes a case

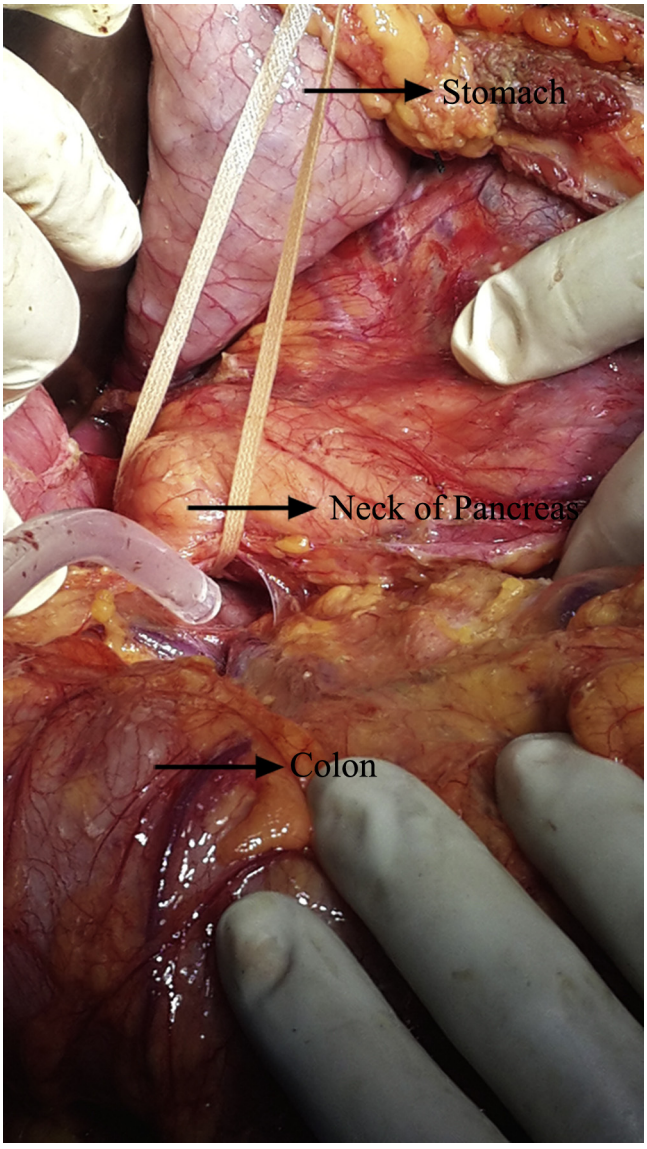

Fig. 2. Picture illustrating the plane of dissection with umbilical tape hooked around the neck of pancreas.