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Case Report

Carcinoma Pancreas Presenting with Jejunal Perforation

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Abstract

Pancreatic cancer is the fourth most common cause of cancer mortality worldwide. Pancreatic cancers commonly present as obstructive jaundice, abdominal pain, and weight loss. Rarely do they present as acute pancreatitis, thrombophlebitis migrans or with a Virchow's node. This is rare case report of a 61 year old male who initially presented with acute pancreatitis, eventually diagnosed with jejunal perforation secondary to carcinoma of the pancreas.

Keywords: Pancreatic malignancy; Jejunal perforation; Metastasis

Introduction

Pancreatic adenocarcinoma is associated with poor outcome (5-year survival of 2% to 9%) mainly due to late presentation of the disease. The Incidence is higher in developed nations compared to developing nations. The risk factors include gender, age, smoking, alcohol abuse, obesity, diabetes, chronic pancreatitis, genetic factors, vitamin D, and dietary factors.

Case Presentation

A 61year old gentleman came with complaints of severe abdominal pain and multiple episodes of bilious vomiting and obstipation. Patient had presented with a similar episode one month back. Patient was a chronic alcoholic with no known co-morbids. On examination patient was tachycardic (PR-125 bpm) and nor motensive. The abdomen was distended, diffusely tender with sluggish bowel sounds. Biochemical test showed elevated serum amylase (486 units/litre) and lipase (927 units/litre). The CECT abdomen (Figure 1) showed collapsed and clumped terminal ileum and ileocaecal junction with wall thickening and submucosal edemaand? Inflammatory narrowing at the level of distal ileum .The head and proximal body appeared normal in bulk, distal body and tail replaced by fluid collection showing features of moderate interstitial edematous pancreatitis. Patient was treated as acute pancreatitis with intravenous fluids, antibiotics and monitoring. On the third day patient had persistent tachycardia, guarding, rigidity and abdominal distension and hence patient was taken up for emergency exploratory with a provisional diagnosis of obstruction secondary to? Necrotising pancreatitis.

At laparotomy, 10 cm gangrenous jejunal segment with 2 cm × 2 cm jejunal perforation, with distal ideal clumping and peritoneal deposits noted (Figure 2). Pancreas appeared hard and calcified. Resection of the gangrenous jejunal segment was done with exteriorisation of the loop as an ostomy. Histopathological report was consistent with adenocarcinoma to us deposits on the serosa of the jejunum. Postoperatively tumor markers were suggestive of pancreatic carcinoma (CEA-7, CA 19-9 -32000) and patient was referred for chemotherapy.

Discussion

Pancreatic adenocarcinoma and its variants account for 90% of all pancreatic carcinomas. Pancreatic adenocarcinoma develops following a series of step-wise mutations from normal mucosa to specific precursor lesions and ultimately invasive malignancy. The premalignant conditions include pancreatic intraepithelial neoplasia, intraductal papillary mucinous neoplasms and mucinous cystic neoplasm. Pancreatic cancer present with malignant variants such as ductal adenocarcinoma (most common), mucinous adenocarcinoma, acinar cell carcinoma, small cell carcinoma and with uncertain malignant potential like mucinous cystadenoma, solid and cystic papillary neoplasm. Ductal adenocarcinoma occurs in the head and less commonly body and tail, usually present late with early metastasis.

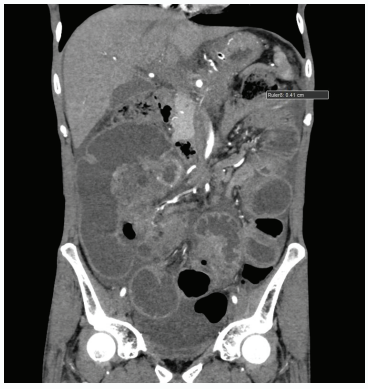

Figure 1: CT Showing Distal ileal narrowing with wall thickening with dilated bowel loops.

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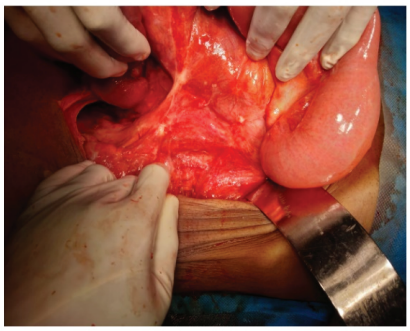
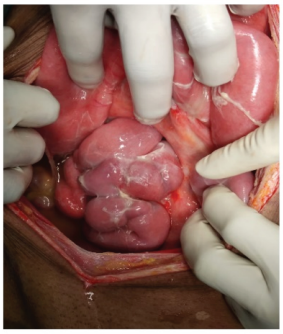

Figure 2: A) At Laparotomy, Omental deposits and B) The clumped distal Ileum.

For the rare tumors in the pancreas, the clinical features often vary, and are detected late. Pancreatic cancers can occasionally present as lower gastrointestinal bleed [1], Upper gastrointestinal bleed, Multiple cerebral infarction of brain [2], pancreatic schwannoma arising from the peripheral epineurium of autonomic sympathetic or parasympathetic fibres [3], metastasis to head and neck [4], anaplastic pancreatic carcinomas presenting with splenic infarction [5], cutaneous manifestations such as metastasis to umbilicus [6], mediastinal lymph node metastasis, They may also present as colonic malignancies, ovarian or uterine carcinomas. The rare causes of bowel perforation documented are perforation secondary to ischemia, small vessel vasculitis, crohn's, foreign body. However, ectopic pancreas is also known to cause small bowel perforation [7].

Diagnostic modalities include CT in assessing the resectability, vascular invasions and Metastasis and staging of the disease. EUS Guided tissue specimen analysis [8], MRI in accurate staging and surgical resectability. ERCP is used in diagnosing pancreatic head carcinomas. Tumor markers such as CA 19-9, CA 125, CEA, CA242, [9,10] micro RNAs and K-RAS helps in preoperative diagnosis and prognosis.

Surgical resection is the main stay of treatment and can prolong survival [11]. Neoadjuvant chemotherapy (Modified Leucovorin, 5 -Fluorouracil, Irinotecan, Oxaliplatin) as a 6 month course helps in down staging the disease and improves patient survival [12]. Radiotherapy is used in patients with locally advanced pancreatic cancers. Recent advancement is targeted therapy with new targets such as PEGPH20 and CKAP4 [13].

Conclusion

Pancreatic carcinomas present as obstructive jaundice or a metastatic node and atypical presentations are uncommon. The surgeon must be aware of rare possibilities when he encounters perforations at uncommon sites.

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