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Case Report

MISSED CARCINOMA OF PANCREAS AT OPEN CHOLECYSTECTOMY

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INTRODUCTION

Carcinoma of pancreas is a common malignancy[1]. It has been found more in people with tobacco smoking, diabetes mellitus and cholelithiasis[2]. Reports have appeared where the carcinoma of pancreas and other malignancies have been missed during laparoscopic cholecystectomy[3-5]. Here are described two cases, where the carcinoma of pancreas was not diagnosed before the surgery and open cholecystectomy was performed for gallstones. Carcinoma of the pancreas was diagnosed soon after the surgery in these patients.

CASE REPORTS

Case No.1:

This patient was 53 years old male, who presented at another hospital with the constipation, abdominal heaviness and vague abdominal pain. He had fifteen years history of smoking one packet of cigarettes per day but denied any intake of alcohol. He had history of hypertension and had been on Metoprolol and Captopril for past six years. His physical examination showed normal vital signs. Abdominal examination showed no masses or tenderness. Abdominal sonography revealed multiple gallstones. He underwent open cholecystectomy. His abdominal pain, however, did not improve and, in fact, worsened and he presented to our hospital where he was found to have a wound which had healed well. His laboratory findings showed hemoglobin of 12.2 g/dl, hemotocrit was 38%, WBC count was 12800 /ul, platelet were 333,000, total bilirubin was 0.8, direct bilirubin was 0.24, AST was 31 U/l, ALT 54 U/l, alkaline phosphatase was 275 (Normal 39-117), creatinine was 0.7 mg/dl, serum amylase was 99 U/l (Normal 28-100 U/l), serum lipase was 90 (Normal <190). Abdominal sonography at this time showed a mass in the pancreas which was confirmed on the CT scan which revealed 5 x 5.5 cm mass in the body with retroperitoneal lymphadenopathy. CT directed fine needle aspiration was positive for malignant cells. Patient refused any further surgery.

Case No. 2:

This patient was 48 years old male, who presented at another hospital with abdominal pain. No previous history of any other illnesses was present. He had sonography which showed multiple gallstones and then he underwent open cholecystectomy. Within a

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week of the surgery, his LFT's were abnormal and his pain in the abdomen had increased and he came to our hospital. He had normal vital signs and liver was six cm enlarged. His hemoglobin was 13.1 g/dl, hematocrit 42.5 %, WBC count 11700 /ul, platelet 274000, serum amylase was 112 U, total bilirubin was 7.1 mg/dl, direct 6.45 mg/dl, AST was 161 U/l and ALT 283 U/l, alkaline phosphatase 364 (Normal 39-117), serum creatinine 0.8 mg/dl. He had abdominal sonography which showed mass in the pancreatic head and a dilated common bile duct with a diameter of 1.2 cm. He underwent laparotomy, and a choledochojejunostomy and gastrojejunostomy were performed as the tumor was unresectable. Histopathalogy of the tumor tissue taken at surgery showed poorly differentiated adenocarcinoma of the pancreas.

DISCUSSION

Pancreatic carcinoma is a common tumor world-wide[1,6]. It has been associated with several risk factors which in these cases were cigarette smoking and cholelithiasis. Clinical presentation of this cancer can be vague, although pancreatitis can be presenting feature in some cases[7-9]. After cholecystectomy, a period of one month to one year has been noted when carcinoma of pancreas was discovered[5]. In our cases it was 1-2 weeks when new symptoms were noted or initial symptoms failed to improve. These cases illustrate the pitfalls of ultrasonography in the diagnosis of carcinoma of pancreas where, after seeing gallstones other associated pathology may be overlooked. Also, since pancreatic abnormalities were noted on the ultrasonography post operatively, at a different institution, this situation also highlight the observer variability in the interpretation of sonographic images. This clinical scenerio reminds the clinician the difficulties faced in the diagnosis of cancer of pancreas. Should patients with gallstones on ultrasonography have CT scan to evaluate pancreas, as sonography is not the best means for the detection of carcinoma of pancreas? This question needs further thoughts.

In conclusion, although cholelithiasis is much commoner than pancreatic carcinoma which may present with vague features, it seems fair to state that any time a patient has abdominal pain, even if vague, the work up has to be relatively adequate and pre-operative evaluation must consider the associated risk factors. A possibility of an abdominal malignancy should be kept in mind and all other organs may be examined carefully during an open cholecystectomy.

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