

Large-bowel obstruction caused by pancreatic tail cancer

A 60-year-old man presented to our hospital with abdominal pain. Enhanced abdominal computed tomography (CT) revealed a well-demarcated, low-density tumor in the tail of the pancreas (● Fig. 1). ^{18}F -fluorodeoxyglucose positron emission tomography (FDG-PET) showed high uptake in the tumor (standardized uptake value 17) (● Fig. 2). Colonoscopy revealed a mass in the descending colon causing marked stenosis (● Fig. 3). Consistent with this finding, the colonoscope could not pass through the obstructed segment. CT colonography revealed an apple-core lesion in the descending colon (● Fig. 4), and histological examination of the biopsy samples revealed poorly differentiated adenocarcinoma. A few days later, the patient was admitted with abdominal pain due to acute large-bowel obstruction. Emergency distal pancreatectomy, left hemicolectomy, and partial adrenalectomy and lymph node dissection were carried out. Gross examination of the resected specimen showed a submucosal tumor of the colon with the majority of the tumor residing in the pancreas (● Fig. 5). The patient was diagnosed as having anaplastic pancreatic cancer with osteoclast-like giant cells. Postoperative follow-up at 2 years showed no recurrence.

High accumulation of FDG in FDG-PET is somewhat rare in pancreatic ductal adenocarcinoma due to the scattered distribution of cancer cells [1]. Thus, pancreatic tumors with high uptake should be considered atypical. Anaplastic pancreatic carcinoma is a solid-type tumor with poor prognosis; however, the presence of osteoclast-like giant cells is associated with relatively good prognosis [2]. Acute abdominal pain due to large-bowel obstruction is a rare symptom of pancreatic cancer, and only four cases have been reported to date [3], all of whom died within several months. Thus, extended resection is not recommended in patients with pancreatic cancer presenting with large-bowel obstruction. However, in patients with colonic obstruction due to pancreatic cancer and atypical radiological findings, aggressive surgery should be considered to improve prognosis.



Fig. 1 Abdominal enhanced computed tomography (CT) view of a well-demarcated, low-density tumor, about 4.5 cm in diameter, in the tail of the pancreas in a 60-year-old man with abdominal pain.



Fig. 2 ^{18}F -fluorodeoxyglucose positron emission tomography (FDG-PET) image showing high uptake in the tumor in the pancreatic tail.

Endoscopy_UCTN_Code_CCL_1AD_2AJ

Competing interests: None

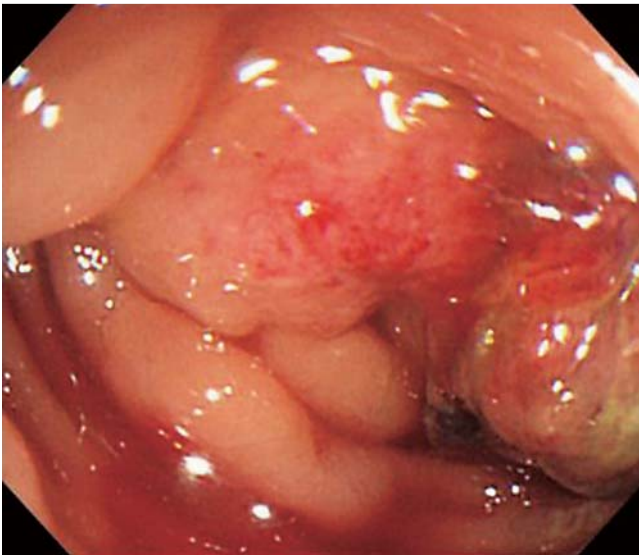


Fig. 3 Colonoscopic view showing tumorous obstruction in the descending colon.

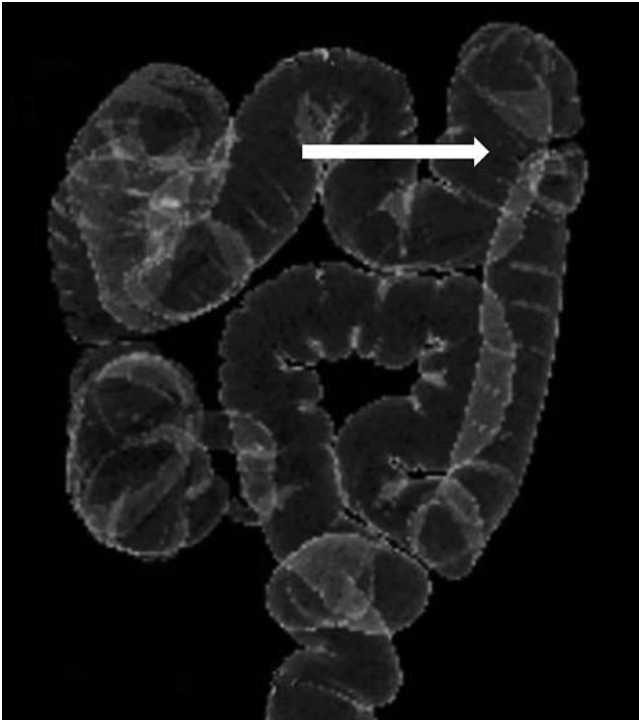


Fig. 4 Computed tomography (CT) colonography showing severe stenosis in the descending colon.

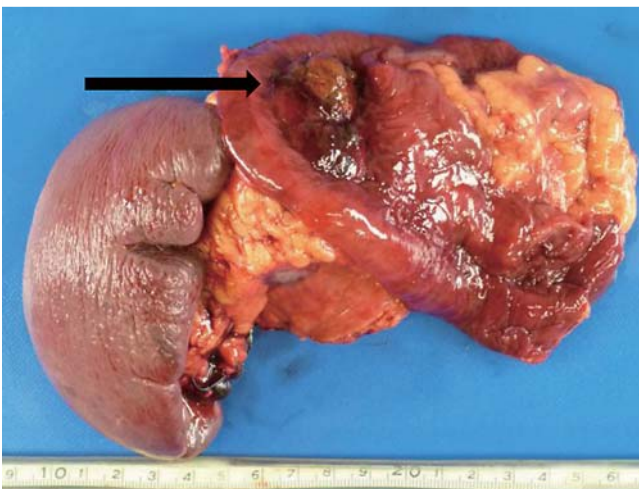


Fig. 5 Resected specimen showing a submucosal tumor of the colon with the majority of the tumor residing in the pancreas.

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References

- 1 Izuishi K, Yamamoto Y, Sano T et al. Impact of 18-fluorodeoxyglucose positron emission tomography on the management of pancreatic cancer. *J Gastrointest Surg* 2010; 14: 1151–1158
- 2 Strobel O, Hartwig W, Bergmann F et al. Anaplastic pancreatic cancer: Presentation, surgical management, and outcome. *Surgery* 2011; 149: 200–208
- 3 Griffin R, Villas B, Davis C et al. Carcinoma of the tail of the pancreas presenting as acute abdomen. *JOP* 2012; 13: 58–60

Bibliography

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