PANCREATIC MUCINOUS CYSTIC NEOPLASM

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Received: 9 August 2016 / Accepted: 26 August 2016

A 37-year-old female with no comorbid was in usual state of health 1 month back when she started having abdominal pain. It was more marked on the left side and radiated to back. Pain was relieved by analgesics and was not associated with nausea or vomiting. There was no past history of jaundice or weight loss. On examination, there was a swelling in the abdomen which was gradually increasing in size.

Investigations showed CA – 19.9 level to be 26.9 U/ml. Computed tomography of the abdomen showed cystic mass arising from the pancreatic body with internal septations and measured around 14 cm [Figure 1]. On endoscopic ultrasound, there was a large mass between the spleen and liver, the origin of which could not be ascertained. CEA levels of cystic fluid were 9557 ng/ml. Fine needle aspiration of mass showed mucinous cystic adenoma.

The case was discussed in multidisciplinary meeting and it was decided to proceed with surgery as the patient belonged to a high-risk group according to Sendai consensus guidelines. Surgery was performed and showed large mass arising from the distal pancreas; therefore, distal pancreatectomy and splenectomy were performed [Figure 2]. Histopathology showed mucinous cystic neoplasm with intermediate-grade dysplasia.

Tumour was 0.5 mm from closest posterior margin. The spleen did not show any significant pathology. 10 nodes were identified which were reactive.

There have been few studies in literature describing the nature of pancreatic mucinous cystic neoplasms.[1] These neoplasms can occur in any part of the pancreas. Solid pseudopapillary tumours are rare, have a low tendency for malignancy[2,3] and are usually located in the pancreatic body or tail. Endoscopic ultrasound has emerged as the investigation of choice for diagnosing such lesions.[4] Sendai consensus guidelines have classified patients into

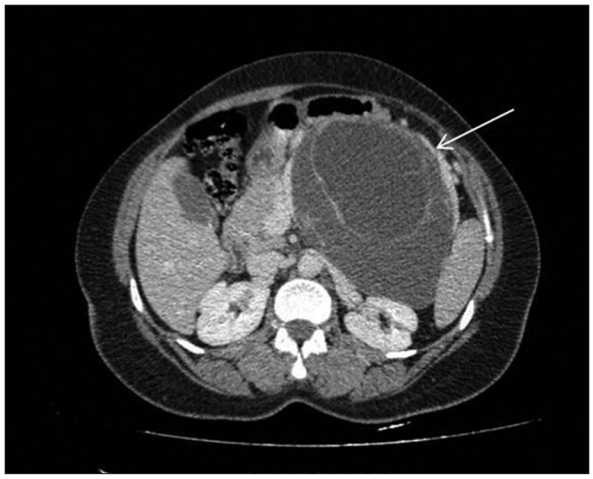

Figure 1: Axial contrast-enhanced computed tomography image showing a large well-encapsulated predominantly cystic multiloculated tumour arising from body and tail of the pancreas (white arrow)

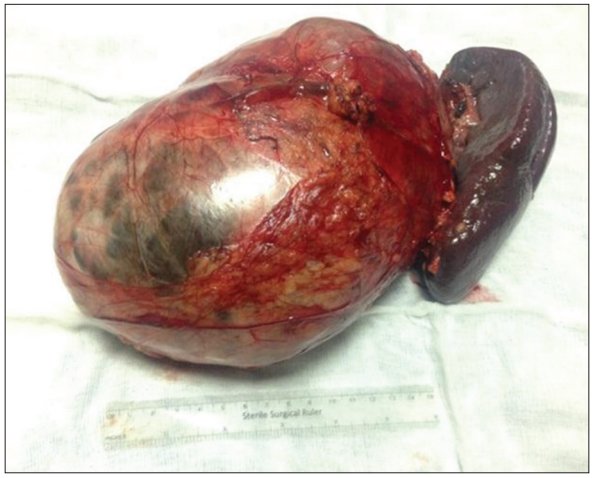

Figure 2: Resected specimen showing distal pancreas with cyst and spleen, removed in toto

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high- and low-risk groups for malignancy. Patients who are symptomatic, lesions >3 cm, solid component and dilatation of main pancreatic duct were classified as high-risk group.[5]

Conflict of Interest

The authors declare that they have no conflict of interest.

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