



A Cystic Form of a Pancreatic Adenocarcinoma Mimicking a False Cyst: Diagnosis Trap

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ABSTRACT

The detection rate of pancreatic cystic lesions has increased since the current use of high resolution imaging. CT-scan, MRI and echo-endoscopy are diagnostic modalities. The pseudocyst is the most common lesion. It is benign and can be managed by endoscopic treatment. Pancreatic cancer accounts for 2% of all tumors, yet it is the fifth leading cause of cancer death. The surgical treatment of these lesions should be discussed within a multidisciplinary team. The interest of this observation lies in the rarity of the published case, both in terms of the location of the tumor and the clinical and radiological presentation leading to a benign tumor of the pancreas which sometimes poses diagnostic difficulties and justifies a discussion multidisciplinary.

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Introduction

Pancreatic adenocarcinoma is the fourth leading cause of cancer death [1]. Tumor-caudal tumors are found later when the tumor mass is large or at the metastatic stage. The risk of finding a cystic lesion of the pancreas is between 13.5 and 19.9% on an abdominal MRI and between 1.2 and 2.6% on a CT scan [2]

We report a patient's observation to discuss the diagnostic and therapeutic modalities of a rare form of pancreatic adenocarcinoma.

Observation

48-year-old patient, with antecedent of treated pancreatitis, admitted for epigastric pain dating back 1 month, evolving in a context of apyrexia and deterioration of the general state (5kg / 3 months), the clinical examination showed Epigastric sensitivity without jaundice or other sign associated with the bioassay showed no signs of infection or pancreatitis, and AC 19-9 were negative. CT was performed in favor of a Cystic Mass Corporeal communicating with the main pancreatic duct of the pancreas associated with a wall enhancement and infiltration of peripheral fat evoking a false cyst of the pancreas. The diagnosis of a false cyst of the pancreas was retained in view of the history of pancreatitis and the radiological data.



Patient operated with a huge exploration of the corporeal pancreatic mass extended towards the head, we decided to make a carcinological resection of this mass. The pathology of the room was in favor of a moderately differentiated adenocarcinoma.



Discussion

Pancreatic ductal adenocarcinoma accounts for 90% of pancreatic cancers diagnosed [3], 60% of these tumors are located in the head, 15% in the body and 5% in the tail. [4]

Cystic or pseudocystic forms of pancreatic adenocarcinoma are rare. These are often large lesions with central necrosis. Some lesions less than 20 mm may, however, be in a cystic form [5]. They translate into CT by a formation of predominant hydrous density.

Cystic lesions of the pancreas have long been underdiagnosed and knowledge about them is limited [6]; Currently, the increase in the number of cystic lesions diagnosed, resected and analyzed has advanced our knowledge of these pathologies [7] The emergence of IPMT as a separate entity has brought other dimensions to a subject dominated by clinical cases and small series [8].

Lee et al. [9] reported that the risk of occult cancer is 3.3% in the presence of an asymptomatic cystic lesion of less than 3 cm without radiological evidence of malignancy. On the other hand, 90% of patients with malignant lesions are symptomatic.

Currently, general recommendations are monitoring patients with cystic lesions less than 2-3 cm, in the absence of red flags in radiology/echoendoscopy (solid component, Wirsung ≥ 0.5 cm and/or wall nodule), at the clinic (symptomatic cyst and/or family history of pancreatic cancer) or cytology, if a puncture is performed (no high grade lesion). However, the opinion of an expert center with a multidisciplinary discussion is advisable in order to validate the therapeutic attitude [10].

The presence of inflammatory signs may mask the underlying tumor and delay the diagnosis. An average duration of symptoms of eight months before the diagnosis of carcinoma has been reported with a diagnostic delay of up to 12 months.

Conclusion

Given the serious prognosis of adenocarcinoma of the pancreas, it is legitimate to consider optimal surgical treatment as soon as possible. Any surveillance or treatment regimen must be discussed within a multidisciplinary team (surgeon, gastroenterologist, interventional radiologist) who is familiar with such pathologies.

Conflicts of interest

The authors do not declare any conflict of interest.

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