Afternoon Session Cases

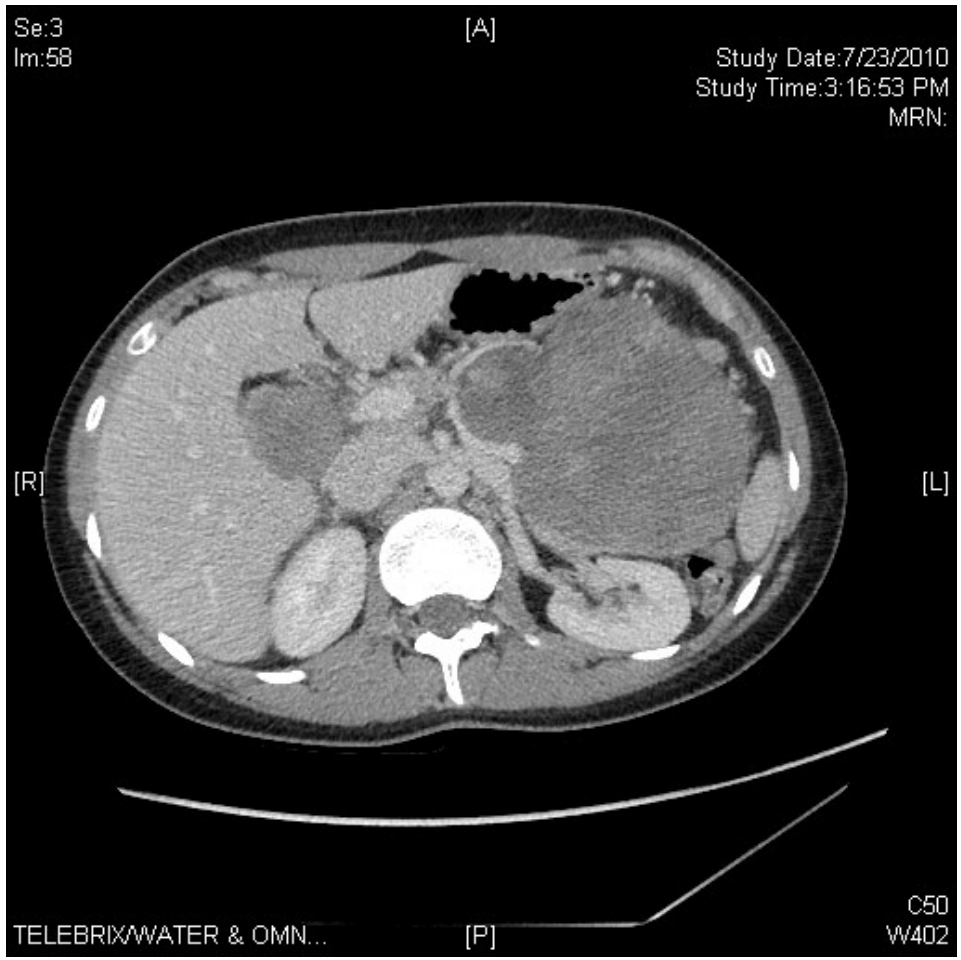
Case 1

- 19 year old woman
- Presented with abdominal pain to community hospital
- Mild incr WBC a14, 000, Hg normal, lipase 100 (normal to 75)
- US 5.2 x 3.7 x 4 cm mass in porta hepatis
- 14 x 10.1 x 8.4 cm mass related to tail of pancrease (heterogenous)

Case 1

- CT scan
- 12 x 9 x 16 cm retrogastric mass related to tail of pancreas
- Heterogenous, with possible punctate calcifications
- Lesion at porta 3.6 x 4.1 may be lymph node
- Free fluid in pelvis and pericholecystic fluid, possible mass in cul –de -sac

CT Case 1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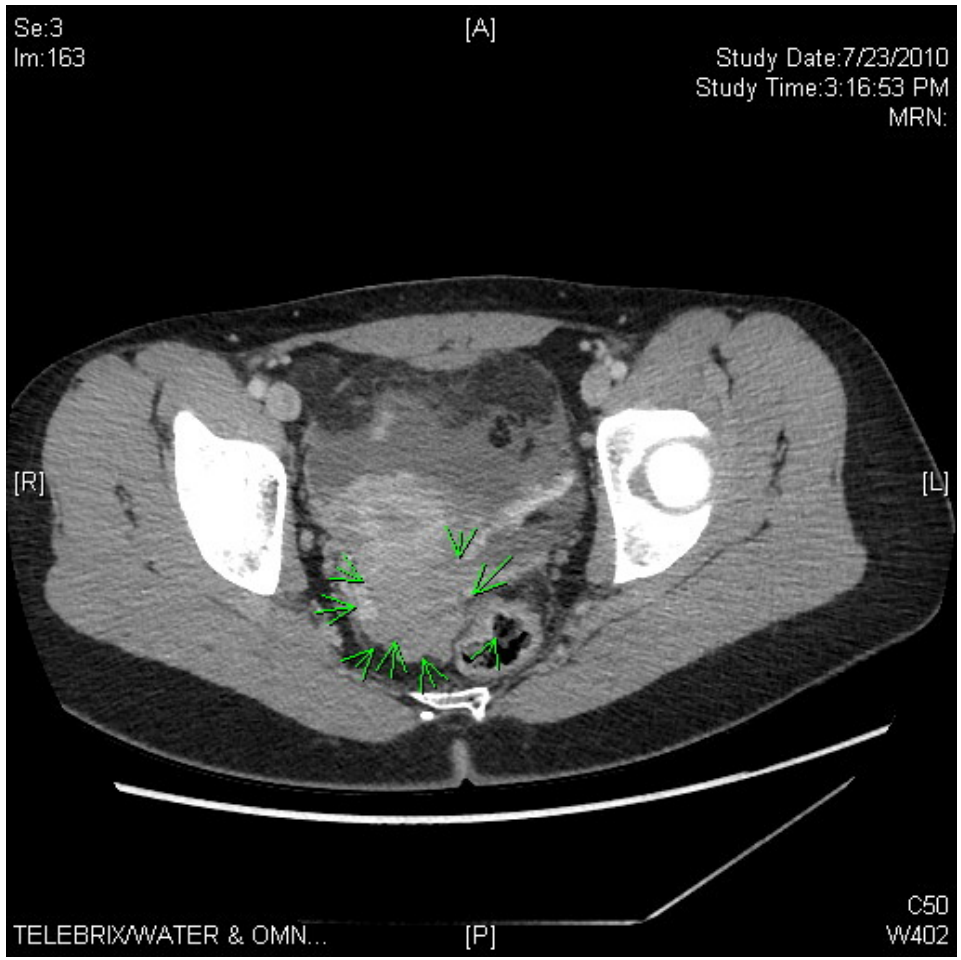
CT Pelvis Case 1



- Pelvic US
- 3.8 x 1.5 x 3.4 cm mass consistent with drop metastases

- CEA and CA 19-9 are normal

- What further investigations?

Case 1

- Percutaneous core biopsy attempted
- Non diagnostic
- Repeat biopsy- solid pseudopapillary tumour of the pancreas
- Recommendations?

Case 1

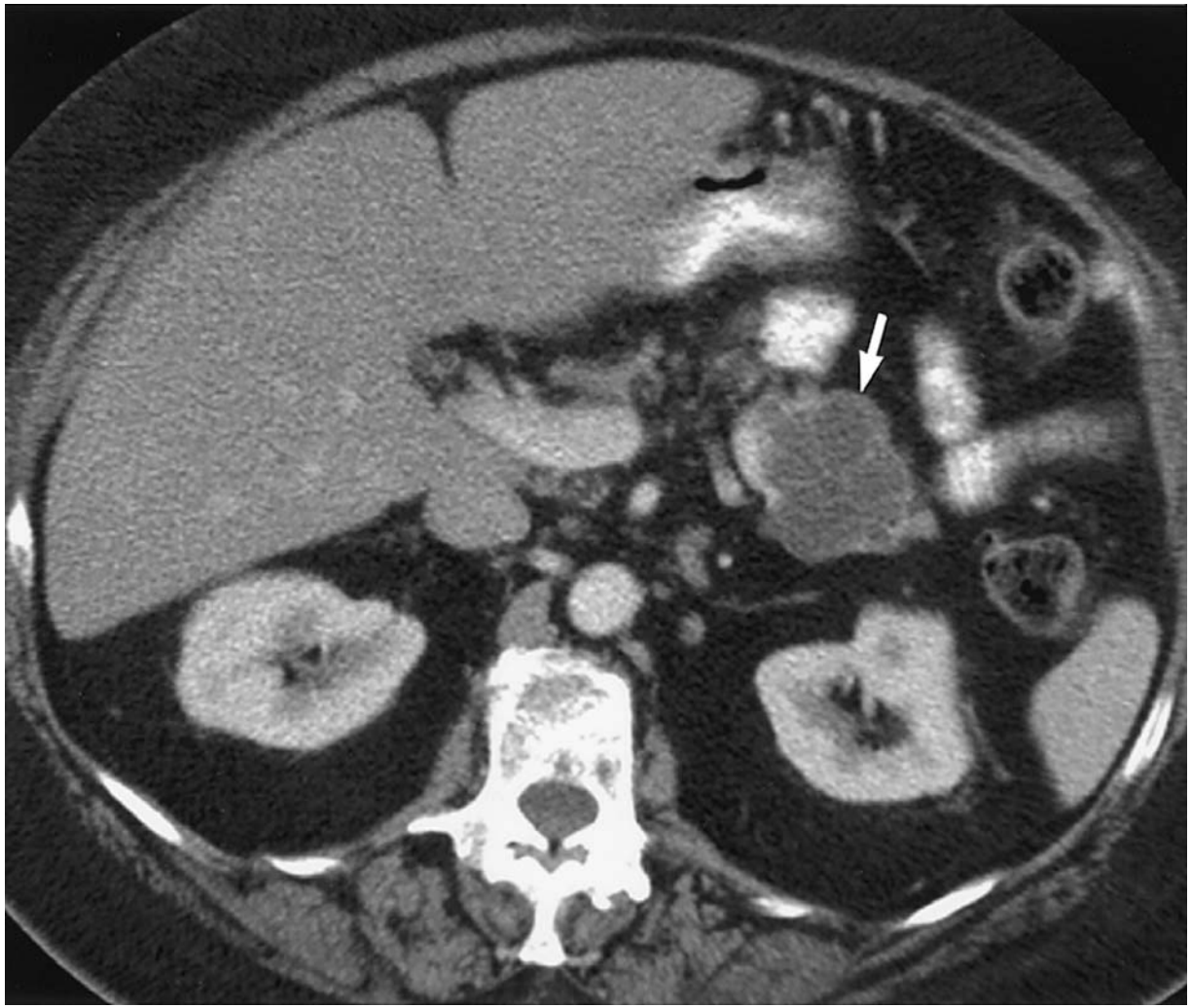
- Taken to OR
- Distal pancreatectomy, cholecystectomy, splenectomy, resection/biopsy of peritoneal implants
- Any role for chemotherapy?

- Solid pseudopapillary tumor, otherwise known as solid and cystic tumor or Frantz tumor, is an unusual form of pancreatic carcinoma. Its natural history differs from the more common pancreatic adenocarcinoma in that it has a female predilection, is more indolent, and carries a better prognosis. Metastatic disease can occur, usually involving the liver, and its management is not well defined.

HPB (Oxford). **2003; 5(4): 264–267.**

Case 2

- Incidental finding on CT scan of pancreatic cystic lesion
- No preceding history of pancreatitis or abdominal pain
- Normal LFTs, amylase and lipase



Kim Y H et al. Radiographics 2005;25:671-685

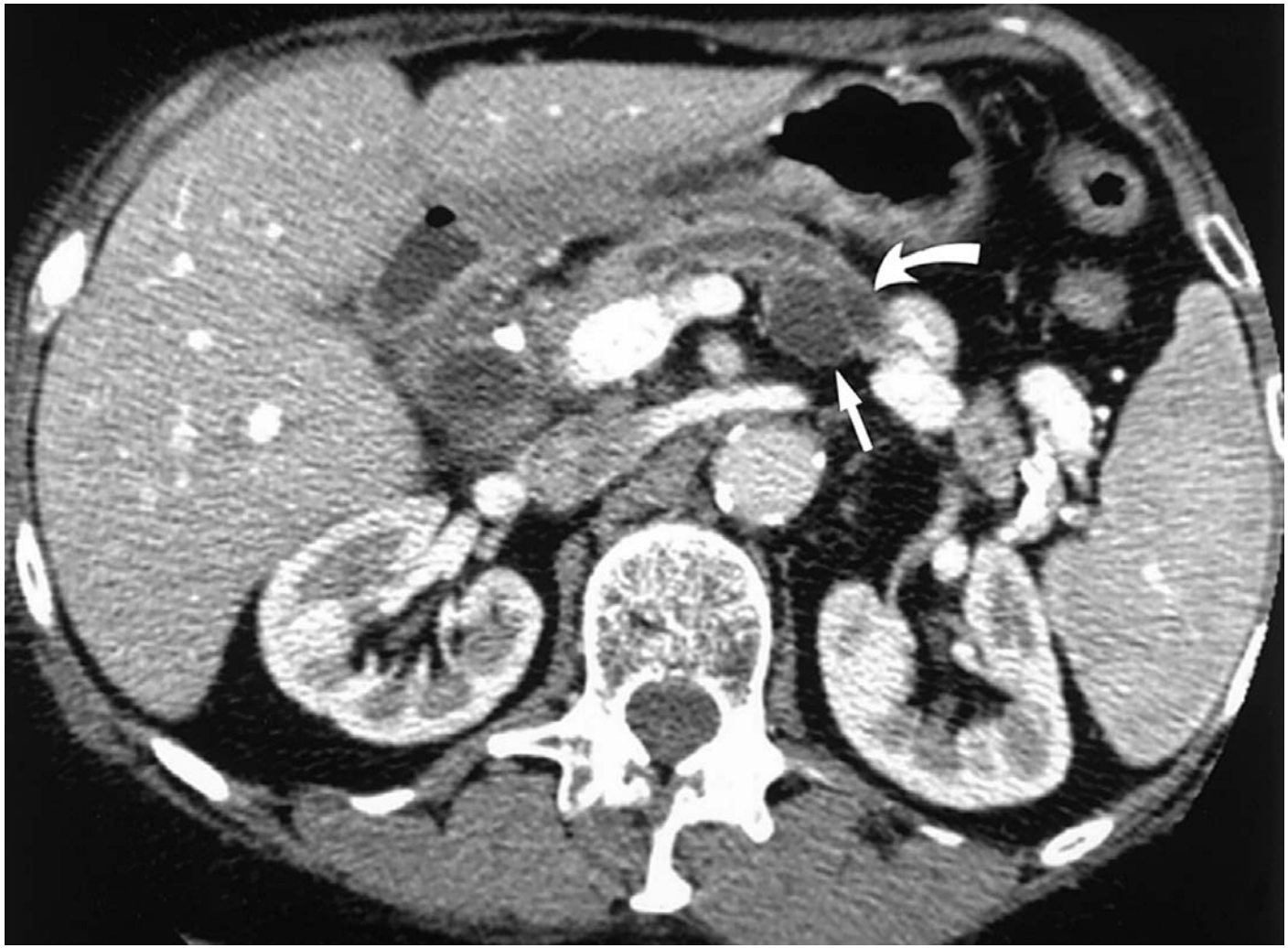
RadioGraphics

Case 2

- What is the differential diagnosis?
- How would you investigate?
- Is there a role for percutaneous biopsy?
- Is there a role for EUS and biopsy?
- How would you manage?

Case 2

- Another pancreatic cystic lesion:



Kim Y H et al. Radiographics 2005;25:671-685

RadioGraphics

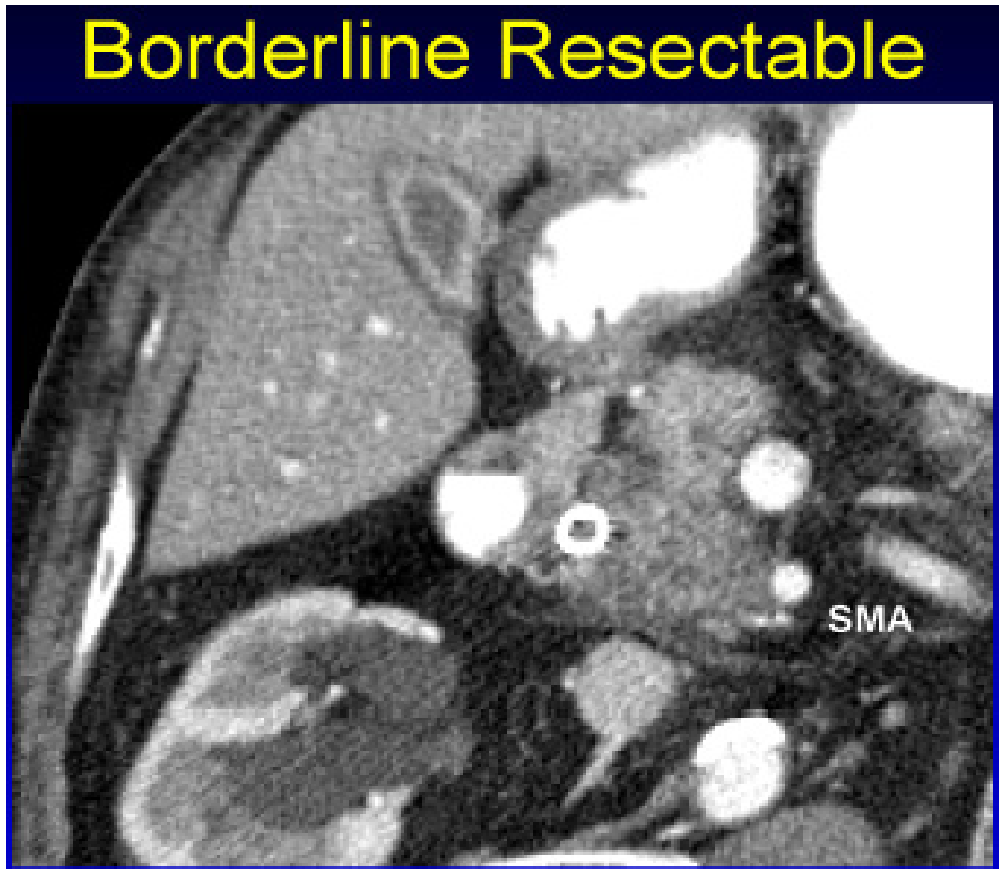
Case 2

- How does this imaging differ?
- Would you recommend any different investigations?

Case 3

- 65 year old otherwise healthy man
- US done for investigation of vague epigastric pain associated with abnormal LFTs
- Mass identified in head of pancreas
- ERCP demonstrated distal CBD obstruction and stent placed
- CXR normal
- CT scan arranged

Case 3



Case 3

- What is the appropriate next step?
- Is there a role for neoadjuvant therapy or should attempted surgical resection be undertaken?
- Are there any official guidelines for this type of problem?

Case 3

- NCCN guidelines in Oncology (NCCN.org)
- Borderline Resectable Pancreatic Adenocarcinoma recommendations are for neoadjuvant chemotherapy with repeat imaging to reassess for resectability
  - Selects those with favorable biology
  - Enhance the chance of a complete (R0, R1)resection
  - Treats occults M1 disease

Case 4

- 53 year old man with anorexia and fatigue
- Abnormal liver enzymes
  - Bilirubin 63
  - Alk phos 378
  - GGT 481
  - ALT 359
  - AST 98

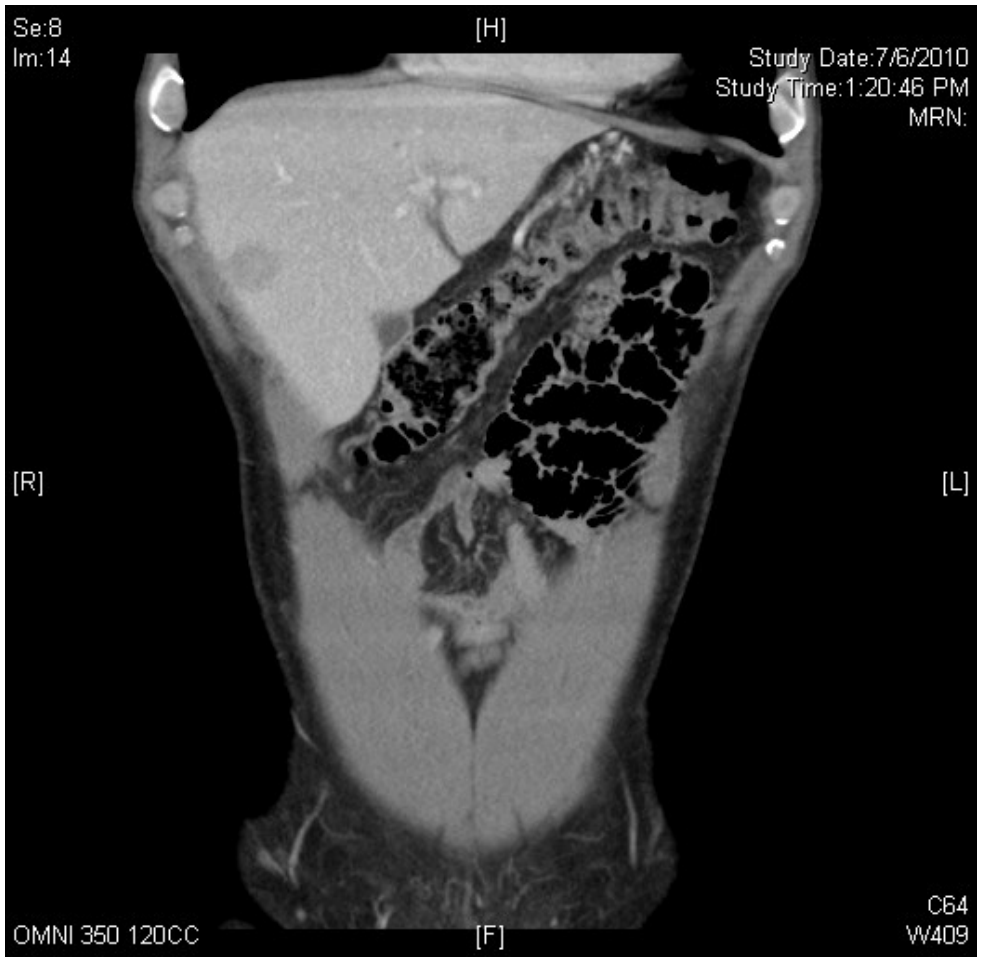
Case 4

- US 2.5cm mass in right lobe liver, 2 lesionas 8mm and 11mm in left lobe of liver
- ERCP shows stenotic ampulla but otherwise normal and LFTs normalize

Case 4

- CT scan (triphasic)
- Liver lesions: 2.5 cm subcapsular in segment V and 10 mm lesion in segment II (adj to middle hepatic vein)
- Hypervascular on arterial phase and wash out on portal phase
- 5.1 cm mesenteric mass in distal SB with multiple enhancing nodes
- Hypervascularity of distal ileum (subtle)

CT Case 4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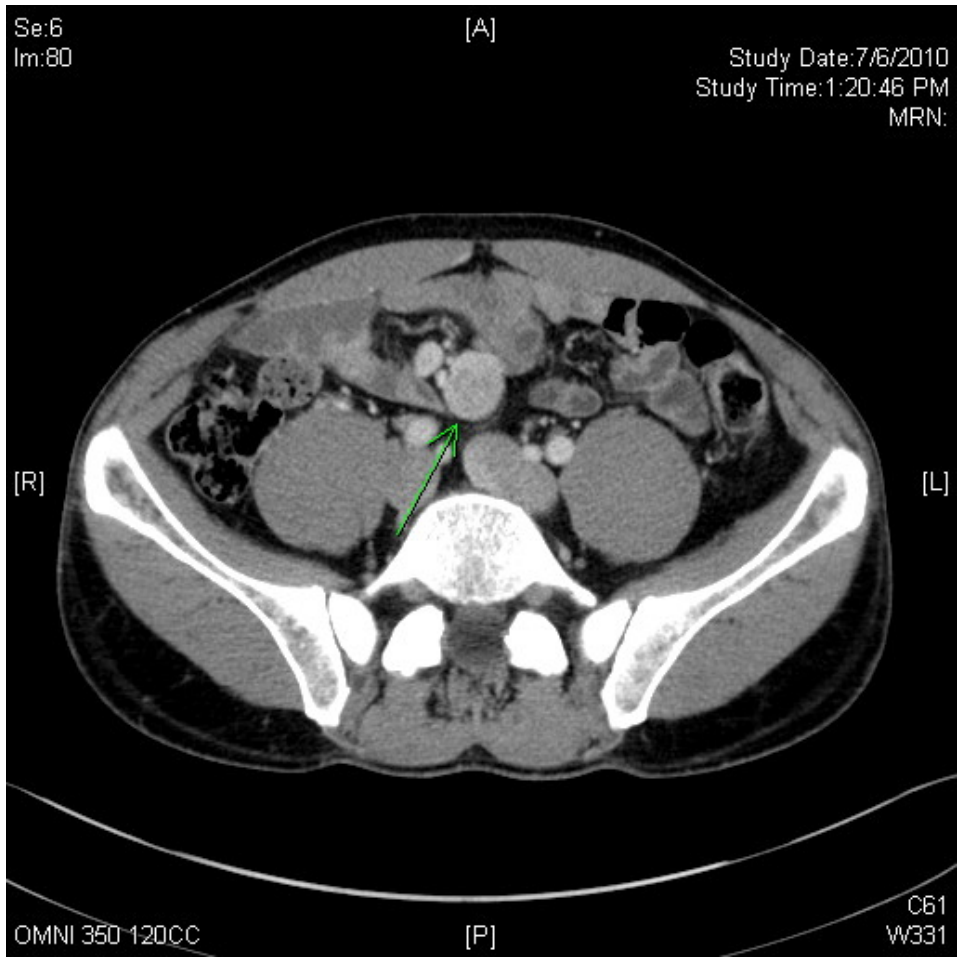
CT Case 4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Case 4

- Radiologist recommendations
- Percutaneous biopsy
- Octreotide scan
- Further investigations?

Case 4

- Octreotide scan positive
- 24 hour urine 5HIAA- normal
- Serum chromogranin A - normal
- Further history- no episodes of flushing, diarrhea or bronchospasm, no evidence of right sided heart failure

Case 4

- Recommendations?
- What if the liver disease was non-resectable?
- What if the liver disease was resectable but the primary was not?
- Does the fact that the patient is asymptomatic influence your recommendations?

Case 5

- 41 year old premenopausal woman
- T1N0 ER neg PR 1+ Her 2 neg left breast ca
- BCS and SLNBx, Radiation and adj chemo
- c/o epigastric pain 4 months after completion of adjuvant treatment
- US shows 8mm mass LL liver

Case 5

- CT one month later 2cm mass seg 4B
- Biopsy confirms metastatic breast cancer
- Possible 1 cm pulmonary nodule
- Begins palliative chemo

Case 5

- Liver mass continues to grow
- Lung nodule stable
- Chemo changed (sequentially)
- Further enlargement of liver lesion and additional small nodules seen in left lobe
- HPB consult requested
- Recommendations?

Case 5

- PET scan ordered to rule out other disease
- Confirms 3 lesions in Left lobe of Liver
- Largest now almost 10 cm
- No other disease identified
- Is there value in hepatic resection for chemo-resistant metastatic breast cancer?
- Are there any factors that influence outcome?

- Patients with intrahepatic disease progression (5-year OS, 0%) and those with stable disease (5-year OS, 12%) during preoperative chemotherapy administration were 3.5 times more likely to die compared with patients responding to preoperative systemic therapy (5-year OS, 42%; $P = 0.008$).

***Ann Surg.* 2006 December; 244(6): 897–908.**