



Radical Resection HPB Tumors Presenting as Metastatic Lesions: Report of 2 Cases and Literature Review

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Abstract

Introduction: Pts with resectable tumors may have varied presentations. Few of the tumors can present like advanced tumors with metastasis. These cases should be properly assessed regarding lesions masquerading metastasis with having separate resectable pathology.

Methods: We have successfully managed 2 such cases which presented to us with features suggestive of advanced malignancy. In both of cases hypoprotinemic ascitic with primary localized GB mass and tubercular ascitic with encapsulated cystic pancreatic neoplasm, was masquerading advanced metastatic malignancy respectively. These pts underwent treatment of hypoprotinemic and abdominal tuberculosis respectively, followed by reasonable improvement in general condition as well as disappearance of ascitic and abdominal nodules respectively. Case 1 underwent diagnostic laparoscopy elsewhere followed by, radical cholecystectomy with port site excisions 2.5 yrs back at our centre and later underwent multiple port site hernioplasty, case 2 underwent laparotomy and staging with biopsy and 2 month later she underwent spleen preserving distal pancreatectomy.

Result: Both pts underwent 2 operations and they are disease free and surviving till now after 2.5 and 2yrs respectively.

Conclusion: Proper workup and clinical assessment is necessary before declaring any pancreaticobiliary tumor unresectable.

Keywords: Metastatic malignancy; Ca gb; Cystic pancreatic neoplasm; Radical resection; Tubercular ascitic; Hypoprotinemic ascitis

Keywords: Resectable HPB tumors; Metastatic presentation; Hypoprotinemic ascitis; Tubercular ascitic; Radical cholecystectomy; Radical distal pancreatectomy

Introduction

Case 1

60 yr old lady referred to department of GI and HPB surgery for management for GB with ascitic, who underwent diagnostic laparoscopy for supposed to be metastatic ca GB at oncology hospital. Presenting features-Pain and distension abdomen, vomiting, generalized edema for 10 days. Diagnostic laparoscopy and biopsy findings of which were-diffuse ascitis with frozen subheptic region with GB not visualized, was biopsy negative for malignancy (exact site not mentioned). O/E- pt ASA GR3 pedal edema+, ascitic +, abdomen soft no s/o icterus/Lymphadenopathy/peritonitis /Mets Investigations-Hb-9.8gm/dl-, TLC-12700, DLC-N-74%, L-22%, E-2%, M-2%, urea-17 creatinine-0.6, HIV, HBS Ag, anti HCV -ve, serum bilirubin- 0.3, SGOT-98, SGPT-78, ALP-327, alb -2.3 CXR-B/L pleural effusion, tapping done. USG-CBD normal, mass in GB lumen not involving liver, liver normal, moderate ascitis. Ascitic cytology-ve CTSCAN - Mass in GB lumen localized to GB wall filling the lumen with no Mets /LNs, ascitic+ ca 19-9 -3u/ml. Management -She was treated for gastritis, hyponatremia, hypoprotinemia with

PPIs, high protein diet, albumin infusion & TPN for 7 days. After nutritional build up reevaluation showed serum albumin- 3.1gm/dl, CECT findings same with resolution of ascitis. The ascitis was a result of hypoprotinemia as ascitic cytology was negative which disappeared after protein replacement. So decision was taken to proceed with diag. lap & radical cholecystectomy. Intraoperative Findings: Diag. lap-no free fluid, no Mets.

Open: There was localized T2 tumor inside GB lumen no s/o hepatic infiltration, no Mets no HDL/Interaortocaval nodes. Radical ccx with segment 4b+5 resection with standard lymphadenectomy and port site excision done (pic1) HPE -gross-polypoid mass GB lumen with a stalk attached to body of GB (pic-2). Microscopy-Papillary adenocarcinoma GB (T2, N0 (0/10 ln), M0), no port site Mets.

Postoperative course

Pt remained stable oral diet started on day 1, she was discharged on day5. follow up-pt followed up for 2.5yrs every 3

months and USG done every 3m, CTSCAN, LFT and CA19-9 at 6m show no recurrence/derangements .Pt developed incisional hernia at port excision sites managed with mesh hernioplasty after 2.5yrs after doing repeat restaging by CT SCAN abdomen.

Discussion

It's known in literature that any mass in GB can metastasize early without causing very big lesion at primary site and may have dismal prognosis. But it's also logical that any mass which is limited to GB wall has high probability of being localized, if clinical picture suggests this ,the case should be reevaluated individually and fair chance should be given for radical excision even in cases of GB malignancies [1]. According to literature ascitis can be differentiated from malignant ascitis by absence thickening of peritoneum, density 6HU and ascetic cytology being negative [2]. CA19 is increased in 50%-79%. CEA & CA 125 have limited role in conformation. PET CT has no significant role in diagnostic evaluation of Cancer GB over MDCT [3]. Although good results have been reported for cancer GB with single organ involvement but no similar case as ca GB with hypoproteinemic ascetic is reported in literature [4].

Case 2

Presenting features -A 60 yrs old lady presented with progressively increasing painless lump left side upper abdomen for 2yrs O/E - no icterus / pallor/edema /Lymphadenopathy. P/A-15x15 cm non tender mass in left hypochondria.

Investigation: Hb-9.1gm/dl, TLC-4900, DLC-N-86%, L-10%, E-2, M-52%, urea-14, creat-0.6, HIV, HBS Ag, Anti HCV negative, serum bilirubin-0.2, SGOT-18, SGPT-24, ALP-86, alb -2, ca 19-95ng/ml, Amylase-37, Lipase-28, Serumca 19-95u/ml.

1. Ascetic fluid Albumin- 1.8, rest-NAD.
2. USG with doppler SP- Axis was done showed-15x 15cm mass near tail of pancreas with fluid, no wall thickening, No involvement of SA SV, No collaterals.
3. Cect- was done showed 15x 15cm cystic mass in tail of pancreas with setae, no solid areas, No involvement of SA/SV, moderate ascetic +, rt pleural effusion +.
4. Ascetic fluid cytology- -ve.
5. Management- After proper preoperative evaluation pt was taken for laparotomy and spleen preserving distal pancreatectomy.
6. Operative findings-There was 20x 20cm tense cystic mass in tail of pancreas with multiple nodules in peritoneal cavity with ascetic. Biopsy was taken and abdomen was closed. The differential diagnosis was -either abdominal tuberculosis with CPN or metastatic CPN.
7. HPE of peritoneal nodules- Cascading granulomas, AFB-ve.
8. Postoperative Course- pt was given ATT for 8 months. After 2 months pt. Improved and ascitis resolved. Reassessment done with CECT abdomen showed same findings with resolved ascitis.

9. 2nd surgery was done - Spleen preserving distal pancreatectomy with saving SA and SV both.

10. Intraoperative finding of definitive surgery- No nodules/ ascetic. 20x 20cm mass in lesser sac at body and tail of pancreas, medial extent of tumor reaching neck of pancreas with splaying of celiac axis at its upper end. Splenic artery and vein adherent to tumor capsule could be dissected off without compromising radicality. Postoperative day3 drain fluid amylase was 15, drain removed, pt discharged on 4th POD.

11. Histopathology- 20x 20cm cystic mass with mutinous lining, no atypical cells seen s/o mucinous cyst adenoma pancreas.

12. Follow up- every 3 months for 1.5yrs with USG being normal, pt has gained 10kg wt.

Discussion

Patient has presented with features of advanced tumor-large pancreatic mass with ascitis, but on final workup she was diagnosed to have Koch's abdomen. Ascitis was diagnosed to be due to tubercular pathology as carcinoma with metastasis in CPN is very rare [5,6] her tumor markers were normal [7-11] she underwent spleen preserving distal pancreatectomy. Careful preoperative workup established that she had 2 being pathologies which could be cured. This care is rarest as only one case of isolated pancreatic tuberculosis presenting as cystic pancreatic neoplasm is reported in literature [11], but no case is there of abdominal Koch's co existing with CPN and presenting as metastatic tumor.

Conclusion

Pts with resettable tumors may have presentation as lesions masquerading metastasis with having separate resectable pathology. In both of our cases these pts were doubted to have unresectable pancreaticobiliary tumors. In case 1 the lady not only resolved ascitis but appeared fit and happier after our intervention .She underwent radical cholecystectomy and port site excision, later she developed port site hernias which were also operated 2.5yrs after the 1st surgery. In 2nd case pt was cured of abdominal tuberculosis and pancreatic cystic tumor both due to our careful assessment and surgical intervention. Our approach in this case not only restored our opinion about disease and provided fair disease free survival and also their outlook for life has changed .Once timely and properly managed pts with HPB tumors can survive for long. Careful preoperative assessment could save 2 pts life with reasonable survival benefit.

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