Case Snippets

**Mixed exocrine-endocrine pancreatic carcinoma in childhood**

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A 7-year-old boy with mixed exocrine-endocrine pancreatic cancer is presented. This may be the second reported case of such a tumor in childhood. [Indian J Gastroenterol 2005;24:116]

Primary pancreatic malignancies are rare in childhood. They fall into the category of adult-type pancreatic carcinoma or pancreatoblastoma. An unusual type of pancreatic cancer has been described in adults, in which both the acinar and endocrine components constitute significant proportions of the neoplasm. This has been variously designated ‘acinarendocrine cell tumor’, ‘ductuloinsular tumor’ or ‘mixed exocrine and endocrine tumor’. To the best of our knowledge, only one case of such a tumor in childhood has been previously reported in literature.

A 7-year-old boy presented with a large abdominal mass. Physical examination and pre-operative imaging studies revealed a 6 cm x 4 cm solid retroperitoneal mass with no calcification. A differential diagnosis of neuroblastoma or rhabdomyosarcoma was considered. At laparotomy a large tumor was found arising from the tail of the pancreas and adherent to the splenic hilum. The tumor was completely resected along with the tail of the pancreas and spleen.

Microscopic examination revealed an admixture of two components (Fig). The first component consisted of uniform small cells arranged in groups, separated by thin-walled vascular channels and an identifiable rosette formation (endocrine pattern). The second component was made up of groups of small acini, a few showing well-defined lumina lined by cuboidal cells with moderate to abundant pink, granular cytoplasm.

The patient received postoperative sequential chemotherapy (5-fluorouracil) and external beam radiotherapy, which were tolerated well. He continues to be on regular follow-up and is free from disease recurrence more than 6 years later.

Formulation of standard treatment guidelines for mixed exocrine-endocrine tumor in general, and in children in particular, has been prevented by the rarity of the tumor. Multimodality treatment has been shown to prolong survival in adults with adenocarcinoma of the pancreas. A similar strategy for mixed exocrine-endocrine tumor seems to be the best option, which is borne out by this case.

**References**


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Small bowel metastases from esophageal and oropharyngeal cancers

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Intestinal metastases are uncommon. Lungs and skin are the common sites of primary tumor. We report two men (52- and 67-year-old) with small bowel metastases from esophageal and oropharyngeal carcinomas. [Indian J Gastroenterol 2005;24:116-118]
Case 1: A 52-year-old man presented with complaints of difficulty in swallowing for one month. He was investigated elsewhere and diagnosed to have squamous cell carcinoma of the esophagus at 18 cm. On examination he had a palpable left supraclavicular lymph node. Abdominal examination was normal. Chest X-ray and ultrasonography of abdomen were normal. The patient was treated with external radiation therapy, concurrent chemotherapy and intraluminal radiation. He was relieved of dysphagia following the treatment. Upper GI endoscopy two months following treatment revealed no evidence of tumor. There was, however, a small right supraclavicular node.

He was symptom-free for a further five months when he developed severe abdominal pain and vomiting. He was investigated elsewhere and was found to have an ulcerated obstructive lesion in the ileum. He underwent resection-anastomosis and recovered well. Histology was reported as metastatic squamous cell carcinoma. Two months after this he developed multiple hepatic metastases. He was advised symptomatic care and died of progressive liver failure after two months.

Case 2: A 67-year-old man presented with 48-hour history of generalized abdominal pain and constipation. He also had complaints of nausea but no vomiting. He was known to have carcinoma oropharynx for which he had received radiotherapy and concurrent chemotherapy 9 months prior to presentation. His last review 2 months prior to presentation revealed the primary lesion to be under control. The patient had had no prior abdominal surgery.

On examination, the abdomen was distended and there was vague tenderness all over; bowel sounds were hyperactive. There was a painless swelling in the left inguinal region that was not reducible but was tender. Rectal examination was unremarkable and stool specimen contained no occult blood. Abdominal X-ray showed multiple air-fluid levels.

At surgery, the sac was opened through inguinal approach. Purulent fluid was found on entering the sac. Part of the small intestine had multiple perforations and there was congestion proximally. Since the extent of the disease was not seen, exploratory laparotomy was carried out. There were two more perforations in the ileum. The remainder of the abdomen and its contents were completely normal. Fifteen centimeters of the ileum containing multiple perforated lesions was resected and end-to-end entero-enterostomy was performed. His postoperative course was complicated by wound dehiscence.

Histology revealed metastatic squamous cell carcinoma (Figure). His postoperative period was uneventful and he was discharged but did not follow up.

Metastatic disease in the small bowel usually presents with obstruction and rarely with hemorrhage or intestinal perforation. The common primary tumors that metastasize to the small bowel are carcinoma lung and melanomas.1,2 During an 11-year period in which there were 6006 hospital admissions for lung cancer, McNeill et al1 had six patients with clinically apparent bowel metastases. Most of the cases presented with perforation. They concluded that this unusual problem may occur with greater frequency as patients with lung cancer survive for longer periods of time. This could also be the case for other malignancies. There are, however, very few cases in literature where small bowel metastasis has occurred from a primary esophageal or oropharyngeal tumor.3,4

Miller et al5 in their 11-year audit of small bowel obstruction secondary to malignant disease, opined that operative treatment has better outcome than nonoperative management in terms of symptom-free interval and re-obstruction rates, though there is high postoperative morbidity. They recommend a short trial of nasogastric decompression followed by surgery if there is no symptom relief and the patient’s general condition indicates that they will survive the operation.

In patients presenting with an acute abdomen who have a history of malignancy earlier, a differential diagnosis of secondary neoplasm must be considered. Decisions regarding operative management must be based on the nature of primary malignancy, presence of other secondaries, and outcome of nonoperative management.

References

4. Waisberg J, de Oliveira MV, Anderi Junior E, de Carvalho GT. Isolated metastasis of squamous cell carcinoma of the