Primary clear cell carcinoma of the pancreas

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Introduction: The authors report a rare case of clear cell carcinoma diagnosed in the pancreas.

Case report: A 53-year-old man, with history of appendectomy, presented to our hospital with epigastric pain, radiating to the back that started a week ago. Laboratory findings showed WBC 13,810/mm^2, CRP 1.47 mg/dL, and lipase 178 IU/L. Amylase level (67 IU/L), CA 19-9 and CEA were within normal. CT showed a 1.7cm-sized enhancing nodular lesion at the pancreas body, accompanied with mild peripancreatic fat infiltration, suggesting of acute pancreatitis. MRI showed a 1.7cm-sized thick peripheral enhancing lesion with central hemorrhagic cystic component with mild DWI restriction at the pancreas body with mild acute pancreatitis around pancreas tail. First impression of the pancreas mass was pancreatic neuroendocrine tumor. On EUS examination, a 1.5cm-sized oval shaped hypoechoic mass with central cystic component was noted at pancreas body with early arterial enhancement. Cytology from EUS-FNA specimens revealed just normal lymphocytes and histiocytes infiltration. After undergoing laparoscopic distal pancreatectomy and cholecystectomy, pathology confirmed the pancreas lesion as clear cell adenocarcinoma of stage pT1N0, without lymph-vascular invasion and perineural invasion. Immunohistochemical staining demonstrated CD10 (-), Chromogranin (-), CK7 (+), CK 19 (+), HMB45 (-), Inhibin-a (-), Muc-1 (+), Muc-6 (+), Synaptophysin (-), PAX-8 (-) and HNF1-beta (+). On POD #14, APCT showed localized fluid collection at the distal pancreatectomy site and left subphrenic space, for which PCD drainage was performed. After examining with ERCP, plastic pancreatic stent was inserted due to pancreatic duct leakage. The patient is now waiting for his first adjuvant chemotherapy once his fluid collection and intra-abdominal infection resolves.

Conclusion: The authors present a rare case report of a patient who came to the hospital because of epigastric pain radiating to the back, maybe resulting from acute pancreatitis due to small pancreas body mass. The patient underwent laparoscopic distal pancreatectomy, and was diagnosed for primary clear cell carcinoma of the pancreas.

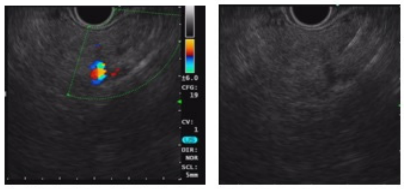

Figure 1. On EUS examination, a 1.5cm-sized oval shaped hypoechoic mass with central cystic component was noted at pancreas body with early arterial enhancement after peripheral injection of microbubble ultrasound contrast agent (SonoVue ®).

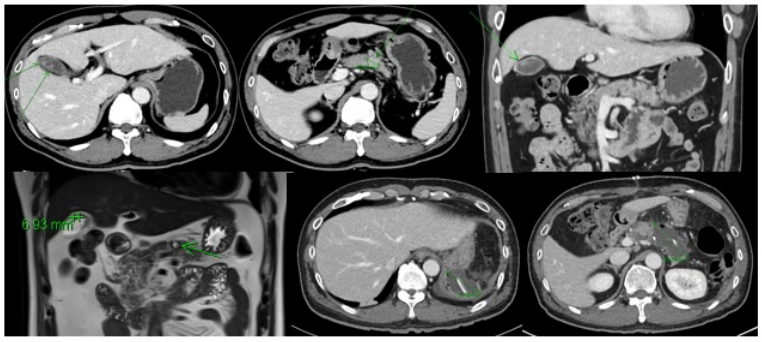

Figure 2. (A) Abdomen CT: Multiple GB polyps (B) 1. Small enhancing nodular lesion at the pancreas body (1.7cm) with mild acute pancreatitis in the upstream pancreas tail. (C) Intraluminal papillary growing enhancing lesions in the GB (D) Pancreas MRI: 1. Small thick peripheral enhancing lesion with central cystic component at the pancreas body (1.7cm). with acute pancreatitis, pancreas tail (E) Localized fluid collection at the distal pancreatectomy site and left subphrenic space

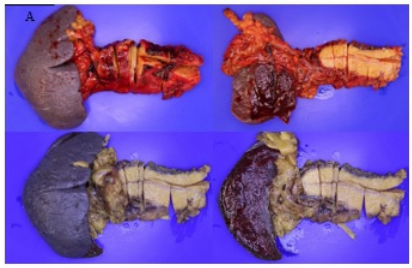

Figure 3. A-B) Laparascopic cholecystectomy: cholesterol polyp
C-D) Fragment of pancreas with spleen attached.