

PICTURES IN DIGESTIVE PATHOLOGY

Intraductal papillary mucinous neoplasm

José Manuel Ramia-Ángel¹, Roberto de-la-Plaza-Llamas¹, María Dolores Sánchez-Tembleque², Belén Pérez-Mies³ and Jorge García-Parreño-Jofré¹

¹Unit of Hepato-bilio-pancreatic Surgery. Department of General and Digestive Surgery. ²Department of Digestive Diseases. ³Department of Pathology. Hospital Universitario de Guadalajara. Guadalajara, Spain

CASE REPORT

A 75-year-old male with a history of dyslipidemia, no alcohol abuse, acute pericarditis and two pancreatitis episodes 16 and 3 years ago, consulted due to a new pancreatitis episode (amylase 536 IU/l). Abdominal CT and MRI showed irregular, rosary-like dilatation of the duct of Wirsung in the body and tail (Fig. 1). In the pancreatic body-tail, echoendoscopy revealed a 15-mm duct of Wirsung with dilatation of the secondary branches and intramural ductal projections. The duct of Wirsung was punctured, yielding mucin material and ductal-type cells without atypias; amylase 38,858 IU/l, CEA 1,604 IU/l and CA19.9 46,000 IU/l. The colonoscopy findings proved normal. Serum CA19.9 was 43 IU/l. With the diagnosis of intraductal papillary mucinous neoplasm of the pancreas (IPMN), a laparoscopic distal pancreatectomy was performed with preservation of the splenic vessels (Fig. 2). The histological study showed an intraductal proliferation affecting the principal duct and secondary branches, with a cylindrical epithelium of intestinal appearance and abundant mucous secretion (Fig. 3). Lacunar mucus accumulations were observed in the pancreatic stroma, without tumour cells. The observed dysplasia proved intense, though without invasive carcinoma (Fig. 3). The surgical margins were free of disease. There has been no evidence of relapse after 18 months of follow-up.

DISCUSSION

IPMN is an infrequent pancreatic tumour (1-3). The current denomination of the disorder was established by the WHO in the year 2000 (1). Three large groups of IPMNs are considered, according to the type of duct involvement: principal duct, secondary branches or mixed presentations. Lesions of the principal duct should be resected in all cases, since 60% present invasive carcinoma. Secondary branch presentations can be monitored provided there is no CA19.9 tumour marker elevation, the lesion measures no more than 3 cm in size, and no wall thickening is observed (1,2). The preoperative diag-



Fig. 1. CT: dilated Wirsung duct in pancreatic body and tail.

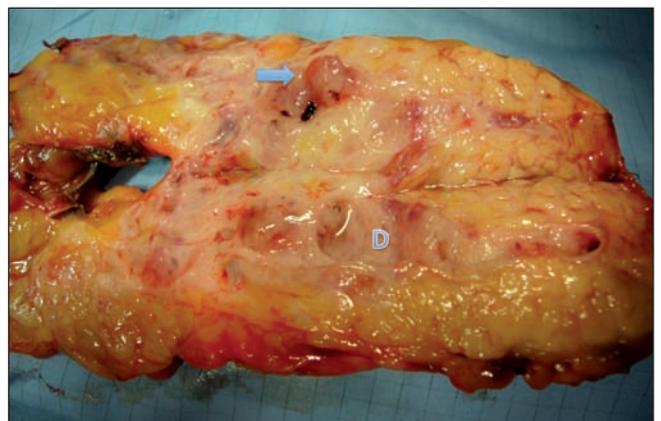


Fig. 2. Surgical specimen. D: dilated duct. Arrow: intraductal papillary proliferation.

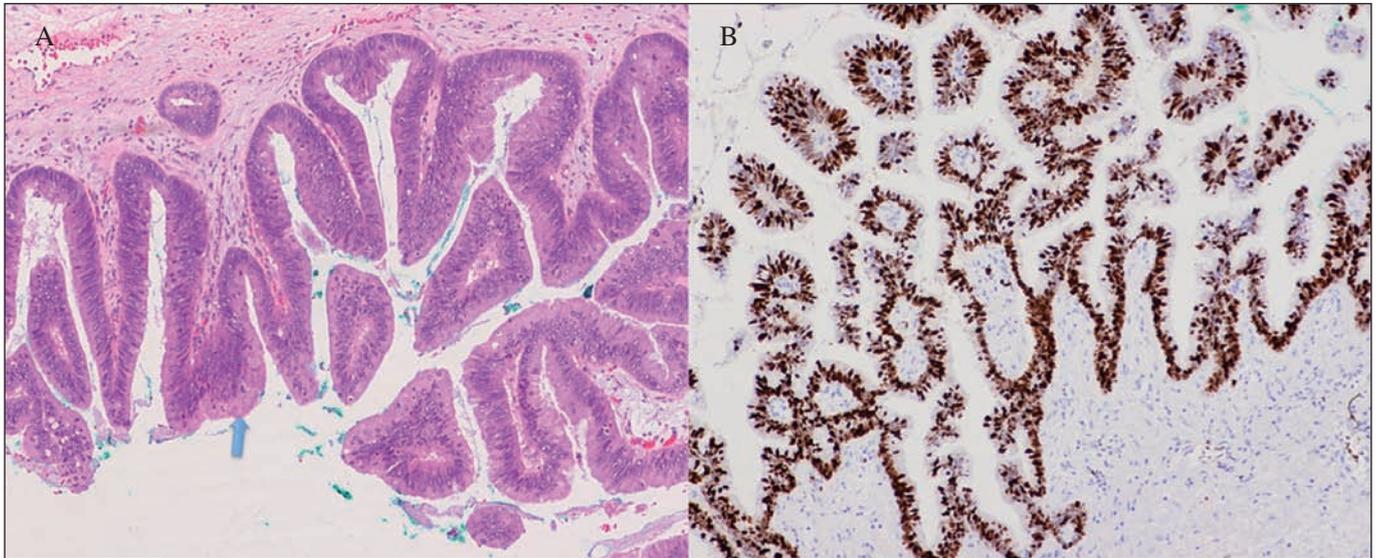


Fig. 3. Histology. A. Arrow: papilar proliferation with mucosecretor intestinal epithelium (hematoxilin - eosin). B. Immunohistochemistry ki67: intense dysplasia without invasive carcinoma.

nosis is established by CT, MRI and echoendoscopy. Laparoscopic distal pancreatectomy with/without splenic preservation is becoming accepted as the best treatment option for disease of the pancreatic body and tail (4).

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