Case Report

Case of Intraductal Papillary Mucinous Tumor (Noninvasive Adenocarcinoma) of the Pancreas Resected 27 Years After Onset

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Summary

A case of intraductal papillary mucinous tumor (IPMT) of the pancreas resected 27 yr after onset is presented. In March of 1997, a 71-yr-old man was admitted to our hospital with a complaint of severe epigastric pain. He had initially undergone endoscopic retrograde pancreatography (ERP) in April 1971 in our hospital and the patient had been followed up for pancreatographic changes for 26 yr. Dilatation of the main pancreatic duct gradually progressed during follow-up, and the filling defect owing to the tumor became demonstrable. On admission, ERP revealed diffuse dilatation of the main pancreatic duct, which was 20 mm in diameter, and the filling defect of 35 mm in diameter. We diagnosed this patient as having an IPMT of the pancreas. Considering his general condition, pancreatic segmentectomy was carried out, and the postoperative course was favorable. Histological findings were compatible with those of noninvasive papillary adenocarcinoma. This is a precious case for studying the natural history of intraductal papillary tumor of the pancreas and to evaluate the application of surgery, because the biologic behavior of this tumor is much less aggressive than that of pancreatic ductal cell carcinoma.

Key Words: Intraductal papillary mucinous tumor of the pancreas; natural history; long-term observation.

Introduction

In 1982, Ohhashi et al. (1) first reported four cases of mucous-secreting pancreatic cancer characterized by dilatation of the main pancreatic duct (MPD) owing to plugging with mucin. There have been many reports about the clinicopathological features and favorable prognosis of this unique tumor (2–6). However, there have been only a few reports (7–9) regarding the natural history of the tumor and changes on the pancreatogram. We report a case of intraductal papillary mucinous tumor (IPMT) (10,11) resected 27 yr after onset and changes on the endoscopic retrograde pancreatograms during 26 yr of follow-up.

Case Report

In March 1997, a 71-yr-old man was admitted to our hospital with a complaint of severe epigastric pain. He had been examined in our hospital for epi-
gastric pain in 1970. He had undergone endoscopic retrograde pancreatography (ERP) in April 1971, and had been diagnosed as having chronic pancreatitis. From 1971 to 1991, he visited our hospital for abdominal pain once or twice a year and took a medication; however, pain attacks became severe and more frequent in 1992.

The ERP performed in April 1971 showed the MPD of normal caliber (Fig. 1A), diffuse dilatation of the MPD up to 9 mm in diameter in February 1976 (Fig. 1B), and a filling defect of 10 mm in diameter within the MPD in January 1980 (Fig. 1C). In December 1983, we recognized an excessive mucin flow through the orifice of the enlarged papilla of Vater and diagnosed the patient as having IPMT of the pancreas. The MPD was 14 mm in diameter and the filling defect 15 mm in September 1994 (Fig. 1D).

Brushing cytology and biopsy of the tumor in the MPD performed during ERP showed findings suggestive of malignancy, but the patient refused to be operated on in spite of our recommendation.

On admission in 1997, laboratory data were as follows: white blood cell count 3630/μL, red blood cell count 423 x 10^4/μL, total protein 6.7 g/dL, serum amylase 351 IU/L, total bilirubin 0.8 mg/dL, aspartate transaminase (AST) 839 IU/L, alanine transaminase (ALT) 702 IU/L, lactic dehydrogenase (LDH) 529 IU/L, alkaline phosphatase (ALP) 406 IU/L, γ-glutamyl transpeptidase (γGTP) 294 IU/L, blood sugar 89 mg/dL, blood urea nitrogen (BUN) 19 mg/dL, creatinine (Cr) 0.7 mg/dL, CA19-9 830 ng/dL, and carcinoembryonic antigen (CEA) 20 U/mL. The oral glucose tolerance test (OGTT) showed impaired glucose tolerance.