Rare case of adult pancreatoblastoma

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DESCRIPTION

A 69-year-old man with a background of hypertension, benign prostatic hypertrophy and Eastern Cooperative Oncology Group (ECOG) performance status 0, presented with abdominal pain and weight loss in May 2018. Biochemistry and full blood count were unremarkable, notably with normal liver function and tumour markers. CT revealed a 5.5×4.5 cm mass in the head of the pancreas, in contact with the superior mesenteric artery and portal vein, with superior mesenteric vein (SMV) thrombus. Endoscopic ultrasound (EUS)-guided core biopsy was reported as acinar cell carcinoma, with immunohistochemistry positive for CD8/CD18, α-1-antitrypsin and α-1-antichymotrypsin. Due to the locally advanced nature of the mass it was deemed inoperable and he went on to receive eight cycles of neoadjuvant FOLFIRINOX. Repeat CT displayed an excellent partial response and subsequently proceeded to an open Whipple’s procedure with resection and reconstruction of the SMV. Postoperative histopathology unexpectedly displayed pancreatoblastoma (figure 1), measuring 3.4×3.7 cm, with staging pT2 N0 M0. The specimen was deemed R1 resection due to viable tumour extending to the anterior pancreatic surface. At 10 weeks post operatively, restaging revealed no measurable disease and he was treated with six cycles of adjuvant gemcitabine and capecitabine chemotherapy.

Pancreatoblastoma is a rare malignant neoplasm of the pancreas with a bimodal pattern of presentation. There have been approximately 40 documented cases in adults since first reported in 1957, and over 200 in children.¹ The tumour more commonly occurs at the head of the pancreas (49% of cases) and the most common presenting complaint is abdominal pain.² It can present a diagnostic challenge as tumour markers are often non-contributory and abdominal imaging may be consistent with both benign and malignant neoplasms as well as autoimmune pancreatitis. The diagnosis is based on histological demonstration of heterogeneous cellularity with acinar differentiation and characteristic squamoid nests (figure 1).³ EUS biopsy may fail to capture these specific structural characteristics leading to misdiagnosis. The aetiology is unknown but it has been associated rare genetic syndromes such as Beckwith-Wiedeman and familial adenomatous polyposis.¹ ³ It is named pancreatoblastoma due to its histological resemblance to fetal pancreatic tissue, and in contrast to pancreatic adenocarcinomas it rarely seems to exhibit p53 and KRAS alterations.⁴ Previous documented cases have suggested that it behaves aggressively, commonly invading adjacent strictures including the duodenum, spleen, superior mesenteric vessels, common bile duct and peripancreatic soft tissue.⁵ Metastasis and/or invasion of adjacent structures has been documented in 58% of cases with the liver being the most common site.²

Pancreatoblastoma is an extremely rare form of pancreatic cancer and there are no established guidelines for management of this aggressive disease. Surgical resection is advised if anatomically possible, and the role of chemoradiotherapy is unclear. It has worse outcomes in adults than in children, but with limited evidence it is difficult to offer accurate prognostics. This case demonstrates the diagnostic challenges and potential role of perioperative chemotherapy in this rare cancer. The disease should be included in the differential diagnosis of pancreatic neoplasms and may only be
diagnosed after thorough histopathological analysis of resected specimens.

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