Chronic Splenic Abscess as the First Manifestation of Pancreatic Tail Tumor

Vui Heng Chong · Muhd Syafiq Abdullah ·
S. Sangkarakumar · Varkey Vallikad Mathew ·
Pemasari Upali Telisinghe

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Abstract Pancreatic carcinoma is still associated with a poor survival due to the late presentation. Excluding head of pancreas tumor, manifestations are often vague resulting in delayed diagnosis. Manifestations as infective complications are rare, and in topic countries where infection remains common, diagnosis will be further delayed. We report a rare case of pancreatic tail carcinoma that manifested as chronic splenic abscess.

Keywords Pancreatic carcinoma · Abscess · Splenic abscess · Neoplasm

Dear Sir,

A 54-year-old man was referred with a few weeks history of intermittent left upper quadrant pain that was associated with weight loss, anorexia, and self-limiting low-grade fever. His past medical history was non-significant. He was a non-

smoker and did not take any alcohol. Clinical examination revealed a two-fingerbreadth liver and no tenderness over the left upper quadrant. Endoscopy showed fundal and gastric varices. Viral hepatitis (B and C) were negative. A computed tomography (CT) scan showed splenic cystic lesions abutting the tail of pancreas. Tumor markers CA 19-9 were elevated at 1,239 U/ml whereas CEA was normal. Endoscopic ultrasound showed a large cystic lesion at the hila of the spleen compressing on the tail of the pancreas and no obvious pancreatic mass. Fine needle aspiration was negative for malignancy and only showed inflammatory changes. Culture was also negative. The patient was treated with co-trimoxazole (960 mg bd). Review several weeks later showed symptoms' improvement with weight gain and declining serum ESR (to 12 mm/h) and CA 19-9. Over the next few months, the patient continued to experience mild intermittent symptoms, but without weight loss. Repeated evaluations (USS and CT) showed similar findings. Colonoscopy was normal. A repeat biopsy 1 month after diagnosis again showed only inflammatory changes. Splenectomy was discussed but the patient declined. Three months later, repeated imaging for increasing abdominal discomfort showed enlargement of the cystic lesions with inflammatory mass infiltrating the pancreatic tail, posterior wall of the stomach, and descending colon. This time, the patient agreed for surgery which revealed inflammatory tumoral mass of the tail of pancreas involving the stomach and colon, peritoneal nodules in the splenic region, and cystic lesions of the spleen. Histology revealed chronic abscess of the spleen with adenocarcinoma cells, with staining pattern consistent with pancreatic carcinoma. The resected tail of pancreas was positive for adenocarcinoma. The patient was referred to the oncology service and treated with several courses of chemotherapy. The patient's condition continued to deteriorate and passed away several months later.

Among the rare manifestations, splenic infarction with or without abscess formations has been reported [1–3]. Splenic

V. H. Chong (✉)
Division of Gastroenterology and Hepatology, Department of
Medicine, RIPAS Hospital, Bandar Seri Begawan, BA 1710, Brunei
Darussalam
e-mail: chongvuih@yahoo.co.uk

M. S. Abdullah
Division of Palliative Care, RIPAS Hospital, Bandar Seri Begawan,
BA 1710, Brunei Darussalam

S. Sangkarakumar
Department of Radiology, RIPAS Hospital, Bandar Seri Begawan,
BA 1710, Brunei Darussalam

V. V. Mathew
Department of Surgery, RIPAS Hospital, Bandar Seri Begawan,
BA 1710, Brunei Darussalam

P. U. Telisinghe
Department of Pathology, RIPAS Hospital, Bandar Seri Begawan,
BA 1710, Brunei Darussalam

abscess in such cases was probably due to bacterial seeding to the infarcted areas. In tropical countries where splenic abscess is not uncommon, this can lead to diagnostic dilemma as in our case. In our case, repeated imaging and two aspiration biopsies consistently showed inflammatory changes. Elevated level of CA 19-9, although fluctuating, and failure to resolve with adequate antibiotic therapy were indicative of an underlying neoplasm. However, elevated CA 19-9 is also observed in benign conditions [4]. The diagnosis would have been made earlier and perhaps at the curative stage had our patient agreed to surgery. In conclusion, our case highlights the need to consider pancreatic tumor in patient presenting with splenic abscess that fail to resolve with adequate treatment.

Conflict of Interest None.

Financial Declaration None.

References

1. Wong M, See JY, Sufyan W, Diddapur RK (2008) Splenic infarction. A rare presentation of anaplastic pancreatic carcinoma and a review of the literature. *JOP* 9:493–498
2. Cipe G, Genç V, Cakmak A, Kuterdem E (2011) Pancreatic cancer complicated by splenic infarction and abscess. *Chirurgia (Bucur)* 106: 523–525
3. Lastrapes RG, Parker JR, Kida M (1995) Pancreatic adenocarcinoma presenting as a splenic abscess: case report and diagnostic approach. *J Okla State Med Assoc* 88:333–336
4. Pavai S, Yap SF (2003) The clinical significance of elevated levels of serum CA 19-9. *Med J Malaysia* 58:667–672