A 79-year-old woman presenting with vomiting was referred to our hospital for the treatment of a pancreatic tumor. The contrast-enhanced computed tomographic examination revealed a hypo-attenuated mass with cystic component in the pancreatic head and body, 7.6 \( \times \) 5.5 cm in size, compressing the portal vein and the common hepatic artery (Fig. 1A and B). There was a tumor thrombus protruding in the portal vein (Fig. 1B, arrowhead).

Figure 1.

Figure 2.

A 79-year-old woman presenting with vomiting was referred to our hospital for the treatment of a pancreatic tumor. The contrast-enhanced computed tomographic examination revealed a hypo-attenuated mass with cystic component in the pancreatic head and body, 7.6 \( \times \) 5.5 cm in size, compressing the portal vein and the common hepatic artery (Fig. 1A and B). There was a tumor thrombus protruding in the portal vein (Fig. 1B, arrowhead).
The patient initially underwent a pylorus-preserving pancreatoduodenectomy, combined with resection and reconstruction of the portal vein. However, the intra-operative frozen section analysis of the pancreatic stump revealed the tumor extension along the main pancreatic duct toward the pancreatic tail. Thus, the remnant pancreas was removed additionally. The cut surface of the tumor showed a yellowish tumor with bleeding necrosis (Fig. 2; note that a color version of this figure is available as supplementary data at http://www.jjco.oxfordjournals.org). Pathologically, the tumor was diagnosed as an anaplastic carcinoma with osteoclast-like giant cells, 11.6 cm in the maximum diameter. The patient is doing well without recurrence 14 months after the operation.

Satoshi Nara
Hepatobiliary and Pancreatic Surgery Division
National Cancer Center Hospital
Tokyo, Japan
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