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RESEARCH ARTICLE

ACUTE PANCREATITIS IN PATIENT WITH HEPATOCELLULAR CARCINOMA–VERY RARE CASE REPORT

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ABSTRACT

Advanced Hepatocellular carcinoma is associated with high morbidity & mortality. Early Hepatocellular carcinoma (HCC) is usually treatable and with surgery it can cure the disease. We present a case of acute pancreatitis in a patient with HBV related Cirrhosis and HCC without any obvious cause. We reviewed the literatures but no article has documented such association.

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INTRODUCTION

Hepatocellular carcinoma (HCC) is the fifth most common malignancy in the world and the leading cause of cancer-related deaths worldwide (1). Prognosis is typically poor because many patients are burdened with un-resectabletumors (2). Well differentiated HCC is mostly dependent on the hepatic artery for blood supply and it is through this characteristic that trans arterial chemoembolization (TACE) procedure is used as an effective palliative treatment for HCC. The procedure is performed by injecting drug eluting beads loaded with chemotherapy agent into the vasculature supplying the HCC which serves a dual purpose of blocking the blood supply and targeting delivery of the chemotherapeutic agent to the tumor. Complications of TACE can result from inadvertent embolization of arteries supplying the liver, gallbladder, stomach and pancreas. Patient can present a rare complication of acute pancreatitis following TACE procedure, likely owing to variant arterial anatomy. But this present case did not have such intervention nor other common precipitants for acute pancreatitis.

Case presentation: 36 year old male from Cuttack, Odisha who was apparently alright in his usual state of health till 10 days ago when he started developing pain abdomen over right and left upper quadrant, gradual onset dull aching type, pain was radiating to back, which is not aggravated by meals and pain was relieved by taking on the counter medication.

The pain was also associated with fever 3-4 days 10 days ago.. There was no history of nausea, vomiting, yellowish discoloration of eyes and urine, abdominal distension, altered bowel ,GI bleeding, altered behaviour, shortness of breath, chest pain and weight loss. Patient was diagnosed as Hepatitis B positive incidentally 8 years ago following which he underwent workup once and was told to be normal for which he was on treatment with alternative medical therapies and did not follow up thereafter till date.

He does not have chronic medical illness

Patient consumed mixed diet with adequate calories. There was history of alcohol intake 10 years back, about 30-45 gms per week. Bowel and bladder habits are normal. There was no history of tobacco or recreational drug use. His present performance status is ECOG PS 0. He was married 2 years back, and his wife is healthy and not tested for Hepatits B. There was no similar illness in the family. On examination, he is moderately build and nourished and BMI is 29 kg/m. Vitals were normal. There was no pallor, cyanosis, clubbing, icterus, lymphadenopathy or ankle swelling. There was no peripheral stigmata of liver disease. On general examination, abdomen was tender and liver was palpable 5 cms below the right costal margin.

Lab. Investigation: Hb-10.1gm/dl, TLC -12550 /mcl, platelets-252000/mcl, Amylase-2304U/L lipase-319U/L, total bilirubin-0.8 U/L, AST/ALT-80/30U/L,GGT-279U/L, ALP-321U/L, protein/ albumin-7.4/3g/dL, INR-1.17, HbsAg-positive, alpha fetopotein->5600 ng/ml.

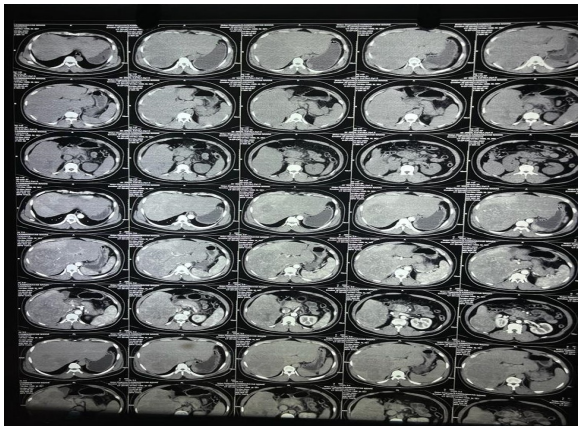

Figure 1.

USG whole abdomen showed enlarged liver in size with large heterogeneously hyperechoic lesion measuring 11.7cm x 11cm with lobulated margin in right lobe of liver extending to right branch of portal vein with hyperechoic ? thrombus in it and bulky pancreas. CECT triple phase showed: Liver is enlarged in size (19.3cms) and shows a large infiltrating SOL of size 14.5 x 15.0 x 12.3 cms in right lobe (Segments V, VI, VII and VIII), No IHBRD seen. Arterial phase-heterogenouslyhyperenhancing lesion, Portal venous phase-Lesion showing contrast washout with central non enhancing (necrosis) component. Lesion encasing the right branch of portal vein with presence of thrombus within it. Delayed phase-Presence of prominent washout seen. Multiple small subcentimetrichypodense lesions with fluid attenuations are noted in right lobe of liver. Findings s/o large hepatocellular HCC with right branch portal vein invasion and thrombosis (LIRARDS-5). Multiple hepatic cysts with interstitial pancreatitis, Figure-1. Liver biopsy was done and showed poorly differentiated hepatocellular carcinoma.

Course in the hospital: He received i/v analgesici/v fluid and other supportive care, His pain improved , no new symptoms noticed during his hospital stay. Repeat S. Amylase and lipase were reduced and patient tolerated orally.

DISCUSSION

Federico and colleagues published a case report in 2015 it showed recurrent acute pancreatitis in a patient with advanced HCC.

Recurrent pancreatitis in this case was due to tumor induced fistula into biliary track causing small fragment of tumor migrated down distal CBD and partially blocking the PD. Acute pancreatitis can result due to TACE for palliative treatment of advanced HHC. In our case , there was no such finding on images nor recurrent episodes. Acute pancreatits of other known aetiological factors are not found in this case. The pathogenesis of acute pancreatits in our case could be postulated due to venous congestion resulting portal venous venous thrombosis which may be less likely cause.

Prior Publication: This article has not been published or submitted for publication elsewhere, in whole or in part, before submission to the Case Reports in Critical Care.

Consent: The authors declare that they have provided informed consent from the described patient for the case report to be published.

Conflict of Interests: The authors declare that there is no conflict of interests regarding the publication of this paper.

Authors' contribution: were involved in the clinical assessment and writing this case report. All authors read and approved the final manuscript.

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