Differential diagnosis in pancreatic lesions with Octreoscan

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Introduction: The most aggressive pancreatic malign tumor is adenocarcinoma, forth cause of death related to cancer. It's differential diagnose must consider the clinical condition, radiologic and pathophysiologic aspects, confirming with biopsy. Clinical case: Male patient, 84 years old, hypertension, and no other comorbities. Chronic osmotic diarrhea, nausea and vomiting, causing intense uncomfortable situation and difficult in social life. It was tried to treat with restrict diet and different medications, with no success. This clinical condition, with no satisfactory evolution motivated a tomographic study of the abdomen (13/11/2016): pancreatic tumor localized in body; liver with homogenous texture. MR (13/12/2016): confirmation of anatomic diagnosis, with no other aspects. Guided biopsy via upper endoscopy (14/01/2017): necrosis area with negative result for neoplasic cells. It was need a new biopsy (24/01/2017): positive to neoplasic cells, but insufficient material for imunohistochemic tests – no definition of the tumor.

Considering the oligosymthomatic evolution and the good overall state of the patient, it was though to be a tumor with indolent behavior – neuroendocrine tumor?

The patient was lead to a scintigraphy with somatostatine analogue: hypercaptation lesions in the liver and in pancreatic body, with counts higher than the hepatic healthy parenchyma, in contrast to PET-CT with 18-F-FDG, which presented concomitant hypercaptation although lower intensity . Chromogranine level was 340ug/dL.

Discussion: differential diagnose of solid pancreatic mass are principally: exocrine primary cancer, neuroendocrine tumor, lymphoma and metastasis. NET are typically hyper vascular, with increase in vascular precocity phase and washout in portal precocity venous phase in the CT contrasted images.

Typically well-differentiated, leading to classic carcinoid syndrome, after tumoral serotonin secretion. The new biopsy quantified ki67, which is valorous information, once the lesions show more affinity to octreotide than the 18-F-FDG, characteristic of well-differentiated tumor (more affinity to somatostatine analogue than glucoses). With these description and low ki67 (ideally lower than 2), this patient is candidate to 177-Lu treatment, with good answer.

Follow up: our patient started 177-Lu therapy, today he is at the second round, in a total of four, referring important improvement of clinical symptoms. There are no renal consequences although a light medullar depression (RBC = 4,47 to 3,94millions/m3; WBC= 6,8 to 4,1tousend/mm),3 which made us choose for a bigger space between the rounds. This answer could be related to the patient age, the medical decision of spacing the rounds does not interfere on the therapeutic results.