Extended Abstract
Volume 5:3, 2021

Hepatology and Pancreatic Science

Open Access

Total laparoscopic benign giant tail pancreatic tumor: Case report

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Abstract

Pancreatic tumor resection remains a challenge in laparoscopic procedures. Several cases must be assisted, or conversion to laparotomy. it's probably pancreas encompasses a specific tissues structure and unique. But, the foremost frequent are due to the fault of designing and fault to place the trokkar itself. A 26 year old female had an intra-abdominal mass on left hypochondrium since four years ago. General condition was almost normal, and had no other complain. She couldn't have normal eating. CT abdominal study found a tumor 12x9x7 cm subcostal region, suspicious from the parenchymal of the tail of pancreas, capsulated, and isolated from the adjacent organs. Laboratory study showed almost normal with HB=11.2 mg/dl. Amylase and lipase of pancreas were normal, LFT normal and specific blood study result was normal.

Laparoscopic procedures were performed with 11 mm umbilical port, 11 mm port LMC, 5 mm port two cm below os, and 5 mm port 1 cm left from the left rectus sheath. Maneuver of the tumor isolated from adjacent organs will be easily identified, with the position of the trokkars. Evacuation of the tumor through the bikini incision was done on the request of patient itself. Postoperative study of the histopathology report was neoplasm, originated from the tail of pancreatic bodies. No mitotic and no proof of malignancy tumor was found. Patient was discharged on day two and no antibiotic was administered for ambulatoire. Day seven after surgery was evaluated, no port-site and bikini incision inflammatory and infection was observed. Activity of daily living at day 8 was observed. Totally laparoscopic pancreatic resection are often performed by every surgeons and depend upon the knowledge of topography anatomica and port placement accuracy.

Tumors of the body and tail, in general, tend to present late until they produce a clinically discernible swelling. By this point the tumor is typically infiltrating adjacent organs or vascular structures and possibly metastasized via lymphatics to locoregional lymph nodes, or by haematogenous dissemination to distant organs. The difference within the time to detection as compared to the tumors within the head is because of the dearth of obstructive symptoms of the biliary and gastric systems. The functioning neuroendocrine tumors, with their characteristic symptom complexes, are often detected provided the clinician is quick to acknowledge these features. The most common symptoms encountered are pain (epigastric, and radiating to the rear, just in case of celiac plexus involvement), weight loss, and new onset DM (especially in patients > 60 yrs). The commonly encountered nonspecific symptoms include anorexia, loss of appetite, weakness and lethargy. The presence of a palpable tumor inadvertently points to a diagnosis of cystadenoma (esp. mucinous carcinomas) or islet cell tumor, as adenocarcinoma is never palpable before demise . Cystic tumors of the pancreas, when symptomatic (approx. 25 - 60%) , produce pressure symptoms. These are more commonly seen in mucinous tumors with the incidence of symptoms correlating with the danger of malignancy. Abdominal pain weight loss and diarrhoea are common .

The less common symptoms are constipation, diarrhoea, abdominal distension, fatigue, early satiety, and within the rare event of functioning tumors, the patient may show signs of hypoglycemia. Hemorrhagic complications secondary to gastric involvement, malignant hypertension, haemobilia, or haemosuccus pancreaticus, will be seen in malignant mucinous neoplasms. In rare cases of SPEN, patients have presented with acute abdominal pain because of rupture of the tumor. IPMNs, when symptomatic, present with signs of chronic pancreatitis and pancreatic exocrine insufficiency, i.e. pain, steatorrhoea, weight loss, urgency, diabetes, etc. they will also present as acute or recurrent pancreatitis. the most distinguishing feature is that the lack of aetiology for acute pancreatitis on obtaining a history in such a patient. Diabetes is found to be related to mucinous tumors especially those who are malignant [26]. Rare associations with Peutz-Jeghers and Zollinger Ellison syndrome are described.

Endocrine tumors present with characteristic syndrome complexes. Insulinomas are characterised by the Whipples triad that features symptoms of hypoglycemia amid plasma glucose levels < 3.0 mmol/L relieved by glucose administration. Gastrinomas cause symptoms of peptic ulceration disease (90%) often not conscious of acid suppressive therapy or related to relapse despite therapeutic compliance. Glucagonomas present with a rash described as dermatitis necrolysis migrans,

anaemia, and weight loss. DM is present in 75-95% patients with glucagonomas. Patients with somatostatinomas show a constellation of nonspecific problems. in additional than 50% of those patients, a characteristic set of findings is cholelithiasis, steatorrhoea, hyperchlorhydria, and weight loss. theopposite endocrine tumors of the pancreas are less commonly found within the body and tail.

This work is partly presented at 11th Global Gastroenterologists Meeting