

Soft-tissue images. Malignant degeneration of heterotopic pancreas

A 60-year-old man, who was a cigarette smoker, was admitted because of epigastric pain of several weeks' duration, accompanied by progressive dysphagia and weight loss. His medical history included a reflux esophagitis with a hiatal hernia, a perforated gastric ulcer treated by suture 38 years earlier and a recent episode of acute pancreatitis due to alcohol abuse. Esophagogastric contrast series and fiberoptic esophagogastroscope showed, in addition to



FIG. 1.

the hiatal hernia, a stenotic, ulcerated mass at the esophagogastric junction (Fig. 1, arrow). Biopsy of the tumour resulted in a diagnosis of adenocarcinoma.

Through a left-sided thoracotomy, the tumour was resected along with the proximal portion of the stomach. Continuity was restored with an esophagogastric anastomosis. Several enlarged lymph nodes were found along the lesser gastric curvature during the surgical procedure, and the liver contained multiple metastases. A biopsy of one of these was done.

The surgical specimen consisted of the distal 5 cm of the esophagus, the esophagogastric junction and the intrathoracic portion of the cardia (3 cm). Gross examination revealed an ulcerated mass that measured 6 × 4.5



FIG. 2.

× 4 cm at the esophagogastric junction (Fig. 2 straight arrow). On sectioning, the tumour appeared to be multicystic, and a few cysts contained polyhedral stones that measured up to 1.5 cm in diameter (Fig. 2 curved arrow). On microscopic examination, the mass corresponded to an aberrant pancreas in which a moderately and poorly differentiated common ductal adenocarcinoma had developed. The malignant tumour took up about two-thirds of the mass. It invaded the entire thickness of the digestive wall and extended widely into the peridigestive soft tissues, reaching the surgical margins. Invasion of the perineural and lymphatic vessels was seen. The esophageal mucosa did not show any changes associated with Barrett's esophagus. The nontumoural pancreatic tissue showed all the elements of a normal pancreas: ducts, acini and endocrine islets. Ductal cystic changes and lesions of chronic pancreatitis were also present.

The patient's postoperative recovery was uncomplicated. No further treatment was planned. In the following months, his condition gradually deteriorated. He became cachectic, experienced several episodes of bronchopneumonia with pleural effusion and eventually died of his disease 3 months postoperatively. ■

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