Concurrent insulinoma and pancreatic adenocarcinoma: report of a rare case and review of the literature

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Abstract
Pancreatic adenocarcinoma is the 5th leading cause of cancer-related death in Western countries and insulinomas are rare endocrine neoplasms of the pancreas. The concurrent appearance of pancreatic adenocarcinoma and insulinoma is very rare and to the best of our knowledge has never been reported again. Herein, we present such an occurrence in a 74-year-old man. Resection of a mass in the uncinate process of the pancreas revealed pancreatic adenocarcinoma with severe desmoplastic reaction. Two years later, due to symptomatology persistence the patient was re-examined and a new 2cm mass in the uncinate process was found leading to surgery, which demonstrated a 2cm endocrine islet-cell tumor. Establishing a diagnosis in patients with insulinoma is difficult and the imaging studies still have low sensitivity and specificity except for intra-operative ultrasonography, which is the most accurate method detecting 90% of these lesions.

Background
Pancreatic endocrine neoplasms are rare tumours with a reported incidence of four cases per million patients per year [1]. Of these tumours, insulinomas are the most common and typically are sporadic and solitary masses affecting individuals 30-60 years old, with equal distribution among genders [2]. On the other hand, pancreatic adenocarcinoma is the 5th leading cause of cancer death in Western countries, and the second cause of cancer death among gastrointestinal tumors [3]. An unusual occurrence of concomitant pancreatic adenocarcinoma and insulinoma in a 74-year-old man is presented herein.

Case Presentation
A 74-year-old man was admitted to our hospital, suffering for the last 2 years from hypoglycaemic attacks. Laboratory tests showed fasting glucose level below 50mg/dl and symptoms of hypoglycaemia such as tachycardia, sweating, confusion and light-headedness. The correction of the above when glucose was administered was significant, so the Whipple’s triad was present. Plasma-insulin level, measured through the extended 72-hours fasting test was found 12mIU/ml and C-peptide level was also elevated, 4.3ng/ml. Tumour markers were within normal range apart from Ca 19-9 which was 51U/ml.

Abdominal ultrasonography (US) did not reveal any lesion, but a contrast enhanced CT scan demonstrated a 1.5cm solid mass in the uncinate process of the pancreas (Figure 1). The patient underwent surgical exploration and pancreas palpation indeed revealed a small solid mass in the uncinate process, which was resected with a small amount of normal tissue surrounding the mass. No frozen section biopsy was done since we believed that the mass represented the insulinoma. However, the histopathological study featured a pancreatic adenocarcinoma of about 1mm in maximum diameter with intense desmoplastic reaction around the lesion (Figure 2). We estimated that the performed resection was enough treatment for such a small carcinoma. The patient’s postoperative course was uneventful and he was discharged on the seventh postoperative day with a regular follow-up as the only recommendation.

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Serial evaluation of Ca 19-9, at 3-month intervals, during the following two years, was found within normal range. Due to persistence of hypoglycaemic symptoms, successive abdominal CT scans completed the follow-up [4] but they were inconclusive because of the increased postoperative inflammatory reaction in the region of the resection. Thus, hypoglycaemic symptoms were classified as idiopathic and were significantly improved with appropriate dietary modifications. After two years, better CT image resolution presumably due to regression of the inflammatory phenomena, rendered the insulinoma mass detectable again, having at that time increased its size from 1.5cm to 2cm (Figure 3). Another operation was decided and pancreaticoduodenectomy was performed. The histopathological examination revealed a 2cm endocrine islet-cell tumour (Figure 4, 5) and the patient was discharged on the tenth postoperative day.

Discussion
The main clinical symptom in insulinoma patients is the inability to suppress insulin secretion in the presence of hypoglycaemia, resulting in neuroglycopenia and adrenergic manifestations like headache, confusion, visual troubles, shivering, irritability and palpitations [5]. However, establishing a diagnosis in patients with insulinoma is difficult and the imaging studies still have low sensitivity and specificity. The sensitivity of abdominal US is 50% whereas in contrast enhanced CT scan is 24%, in MRI scan is 40% and in scintigraphy using octreotide approaches 60%. Endoscopic US is the most accurate non-interventional imaging modality detecting 77% of the pancreatic insulinomas [6,7]. However, intraoperative US is even more accurate detecting 90% of these lesions, which are usually smaller than 2cm in maximum diameter [8].
In our case, palpation of the lesion in the uncinate process during the first operation thought to be the mass, which had been demonstrated on the preoperative abdominal CT. Unfortunately, we missed the 1.5 cm insulinoma and the resected area revealed a 1 mm pancreatic adenocarcinoma with severe desmoplastic reaction in the surrounding tissue, which when palpated obviously misled us to believe that it corresponded to the insulinoma. The patient’s symptoms persisted and serial CT scans revealed the 2 cm insulinoma which was successfully treated with a Whipple’s procedure.

Mixed pancreatic tumours, either collision or composite ones, from endocrine and exocrine cells have been reported in the literature [9], as well as the coexistence of insulinoma and gastrointestinal stromal tumours especially in patients with neurofibromatosis type I [10]. However, the concurrence of pancreatic adenocarcinoma and insulinoma has never been reported before.

Conclusions
The coexistence of pancreatic adenocarcinoma and insulinoma is very rare and has never been reported before. Clinical symptoms should be evaluated carefully and since imaging modalities have low sensitivity and specificity in detecting small endocrine neoplasms, sequential imaging studies and intraoperative US can prove very helpful.

Consent
Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

References