However, there are no precise histological criteria to distinguish benign from malignant carcinoid or carcinoid with metastatic potential. Cure for this disease is directly related to an early diagnosis. But as the tumor is often asymptomatic or has non-specific clinical manifestation, as in our case, the diagnosis and treatment is often delayed. Usually these tumors become symptomatic only when hepatic metastasis occurs, which manifest as classical carcinoid syndrome. However absence of the characteristic carcinoid syndrome does not exclude the diagnosis of carcinoid tumor even in patient with liver metastasis.[4]

In most of the reported cases of primary Pancreatic carcinoid, the tumor was located in the tail or the body of Pancreas,[5] but in our case it was located in the head of pancreas. Although rare, one should be aware of existence of pancreatic carcinoid tumor. For tumors limited to pancreas with no evidence of distant metastasis, a radical resection with lymphadenectomy may be curative.[6]

Shrinivas N, Mongha R, Das RK, Kundu AK
Department of Urology, Institute of Post Graduate Medical Education and Research, Kolkata India
Correspondence to:
Dr. Shrinivas Narayan,
E-mail: drnarayans@rediffmail.com

References

Letters to Editor

Limited resection procedures for carcinoid of ampulla of Vater

Sir,
I read with great interest the article by Rohan et al.,[1] where they have described the management of a rare case of carcinoid of ampulla of Vater. Given the high metastatic potential of these tumors, local resection definitely has a high propensity to leave behind node-positive disease.[2] With the reduced morbidity and mortality rates of Whipple's pancreatic-duodenectomy in high-volume centers, it should be the obvious procedure of choice for these tumors.

However, there are situations where a pancreaticoduodenectomy might not be technically possible, as highlighted in the article by Hwang et al.,[3] where they describe a very rare case of carcinoid tumor of ampulla of Vater associated with diffuse cavernous transformation of the portal vein, secondary to main portal vein obliteration of unknown origin. They had to perform a retrodudenal resection of the ampullary carcinoid tumor, followed by reconstruction using Roux-en-Y pancreaticojejunostomy and choledochojejunostomy.

Few other limited resection procedures have been described in literature for these tumors. The least aggressive of these is transduodenal ampullectomy,[4] which requires in situ reconstruction of the resected duct stumps to the duodenal wall. While the most aggressive procedure described, is a major or total resection of the duodenum, where a jejunal Roux limb is used for anastomosis to the stomach and for reconstruction of the distal CBD and pancreatic duct openings.[5]

In conclusion, due to the technical complexity of these procedures along with the added risk of insufficient resection margins, these limited resection procedures should be considered a choice only in a small number of highly selected patients.

Sharma R
Department of Surgical Oncology, IRCH, All India Institute of Medical Sciences, New Delhi, India
Correspondence to: Dr. Sharma Rajeev
E-mail: rajeevsharma28@yahoo.co.in

References