Acinar cell carcinoma (ACC) of the pancreas is rare and usually presents as a metastasizing tumor with poor prognosis in elderly patients with non-specific symptoms. We describe a case of pancreatic acinar cell carcinoma with peritoneal spread and multiple liver metastases. Abdominal sonography showed a well-marginated echogenic mass with a large central anechoic necrotic portion; CT scanning showed a large mildly enhanced lobulated mass with a low attenuation center and thin rim-like capsular enhancement. Irregular peritumoral peritoneal extension with multiple small low attenuation necrotic areas was also noted. Multiple small well-defined metastatic nodules showing low attenuation were scattered in the liver.

**Index words:** Pancreas, neoplasms
Pancreas, US
Pancreas, CT

ACC of the pancreas is an uncommon tumor with poor prognosis (1–7). Because it is rare, radiologic findings of ACC have been only sporadically described: a large well-defined mass with central necrosis, which tends to metastasize early (3–5), and metastatic fat necrosis is also frequently associated. We describe a case of ACC of the pancreas with peritoneal peritoneal spread and multiple liver metastases.

**Case Report**

A 68-year-old man who had undergone subtotal gastrectomy 11 years previously due to duodenal ulcer perforation was admitted with a palpable left upper abdominal mass. On admission, laboratory results including tumor marker studies were unremarkable. Abdominal sonography showed a well-margined echogenic mass, approximately 10 cm in diameter, and with a large central anechoic necrotic portion, in the left upper quadrant of the abdomen. The mass showed a slightly lobulated contour, and lay on the tail of the pancreas (Fig. 1. A). Several small anechoic cystic spaces were scattered within its solid portion; intra-abdominal lymph nodes were not enlarged. Consecutive abdominal CT was performed. The mass was located in the left upper quadrant of the abdomen, abutting onto the tail of the pancreas, and was mildly enhanced. Sonographically detected anechoic necrotic portions, including one which was large, lobulated, and central, and multiple small cystic spaces at the periphery of the mass were not enhanced. There was a focal area of peritoneal peritoneal extension with a bubbly appearance. Relatively thin rim-like capsular enhancement was noted at the well-margined periphery of the mass. Multiple small well-defined nodules showing low attenuation, were noted in both hepatic lobes (Fig. 1. B, C, D).

The patient underwent exploratory laparotomy. Surgery revealed that the mass arose from the pancreatic tail and adhered closely to adjacent bowel loops. There was considerable irregular, creeping peritoneal tumor extension, probably due to focal disruption of the pancreatic mass, most of which was well-
encapsulated, with a relatively thick, fibrous wall. A dirty yellowish-green necrotic fluid was aspirated from the central portion of the mass. Tissue pathology, as shown by light microscopy, as well as a study to determine immunocytochemical markers, and electron micrography, indicated acinar cell carcinoma of the pancreas including numerous homogeneous electron-dense zymogen granules (Fig. 1. E).

Discussion

ACC of the pancreas is an uncommon malignancy.

Fig. 1. A 68-year-old man with acinar cell carcinoma of the pancreas.
A. Transverse abdominal sonogram shows a well-defined echogenic mass with a large anechoic center with lobulated contour.
B. Contrast enhanced CT scan at the level of pancreas head shows a large mildly enhancing lobulated mass with low attenuation center and thin rim-like capsular enhancement (arrows).
C. CT scan at the level of pancreatic body shows irregular peritumoral peritoneal extension with multiple small low attenuation areas (arrows).
D. CT scan shows multiple small well-defined low attenuation nodules in both hepatic lobes.
E. Electron micrograph shows numerous electron-dense zymogen granules with perinuclear endoplasmic reticulum (× 5000).
and accounts for 1%–13% of exocrine pancreatic carcinomas (1–7). Pathologically, it is a large, lobulated, soft, fairly well-demarcated mass (3). Our case showed similar radiologic findings to those previously reported; they included a large well-defined mass with central necrosis and liver metastasis (4, 5).

Interestingly, our case showed multiple variable sized low attenuation cystic spaces in the mass, histologically confirmed as necrotic foci, and peritumoral peritoneal extension. The large cystic mass may rupture and spread peritoneally, and this may be the cause of the unusual peritoneal tumor extension seen in our patient. Occasionally, ACC is associated with a characteristic syndrome in which disseminated subcutaneous and intraosseous fat necrosis with polyarthralgia is seen (4). The syndrome is characterized by numerous foci of fat necrosis due to excessive secretion of lipase, and these may occur on the trunk and limbs (1). In our case, however, there was no evidence of fat necrosis.

The histological diagnosis of ACCs is usually very difficult; lesions may be erroneously described as undifferentiated carcinomas of unspecified origin. An electron micrograph demonstration of zymogen-like granules in tumor cells and immunoreactivity of these cells to pancreatic enzymes such as lipase, trypsin, and chymotrypsin has proved helpful (2, 6, 7). In our case, numerous electron-dense zymogen granules, with perinuclear endoplasmic reticulum were seen on electron microscopy. This tumor should be differentiated from other pancreatic or retroperitoneal neoplasms such as cystic islet cell tumor, metastatic adenocarcinoma, necrotic neurogenic tumor, and leiomyosarcoma.

References

<table>
<thead>
<tr>
<th>시간</th>
<th>과목</th>
<th>강사명</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Plain radiogram of acute abdomen</td>
<td>임재훈 (성균관의대)</td>
</tr>
<tr>
<td>09:00</td>
<td>US of upper abdomen: anatomy and pitfall</td>
<td>고영태 (경희의대)</td>
</tr>
<tr>
<td>09:30</td>
<td>CT of upper abdomen: anatomy and pitfall</td>
<td>정규명 (고려의대)</td>
</tr>
<tr>
<td>10:10</td>
<td>휴식</td>
<td></td>
</tr>
<tr>
<td>10:50</td>
<td>Hemodynamics of liver and HCC</td>
<td>김은환 (고려의대)</td>
</tr>
<tr>
<td>11:10</td>
<td>Other hepatic tumor</td>
<td>박정민 (고려의대)</td>
</tr>
<tr>
<td>12:20</td>
<td>휴식</td>
<td></td>
</tr>
<tr>
<td>13:30</td>
<td>Disease of GB and biliary tree</td>
<td>차상훈 (고려의대)</td>
</tr>
<tr>
<td>14:10</td>
<td>Tumor of pancreas</td>
<td>강형근 (건양의대)</td>
</tr>
<tr>
<td>14:40</td>
<td>Pancreas inflammation</td>
<td>남경진 (동아의대)</td>
</tr>
<tr>
<td>15:10</td>
<td>휴식</td>
<td></td>
</tr>
<tr>
<td>15:30</td>
<td>Kidney disease</td>
<td>김승협 (서울의대)</td>
</tr>
<tr>
<td>16:00</td>
<td>Prostate MRI</td>
<td>조경식 (울산의대)</td>
</tr>
<tr>
<td>16:30</td>
<td>Female pelvis MRI</td>
<td>변재영 (가톨릭의대)</td>
</tr>
</tbody>
</table>

- 연수교육 책임교수: 차인호
- 연수교육 담당교수: 박철민
- 연수평점: 6점

1. 신청방법: 사전등록: 우편, 전화 또는 FAX 이용
   전화 (02) 818-6183, 818-6193   
   Fax. (02) 863-9282
   당일등록: 연수교육 현장
2. 수강료: 전문의 및 일반의: 5만원(당일등록 6만원)
   전공의: 3만원(당일등록 4만원)
   사전등록마감: 1999년 2월 26일(금요일)
3. 송금구좌: 한일은행 구로동지점 115-017429-12-506 최승희

뇌신경계방사선과학 연수교육 1999년 10월 3일(일요일) 예정