

In the name of God

Shiraz E-Medical Journal
Vol. 12, No. 1, January 2011

<http://semj.sums.ac.ir/vol12/jan2011/89012.htm>

**Acinar Cell Carcinoma of Pancreas Associated with Plasma Cell
Dyscrasia, a Case Report.**

Eishi Oskuie A*, Valizadeh N*.

*Assistant Professor, Section of Hematology, Department of Medicine, Urmia University of Medical Sciences, Urmia, Iran.

Correspondence: Dr. N. Valizadeh, Section of Hematology and Medical Oncology, Department of Internal Medicine, Urmia University of Medical sciences, Urmia, Iran, Telephone: +98(0441) 3370-234, Fax: +98(0441) 3469-935, Email: nседaha0@gmail.com

Received for Publication: June 11, 2010, Accepted for Publication: November 6, 2010.

Abstract:

Acinar cell carcinoma of pancreas is a rare tumor of pancreas which arises from acinar cells of the pancreas. We want to present nephrotic-range proteinuria and plasma cell dyscrasia in a case of acinar cell carcinoma of pancreas.

Keywords: Acinar cell carcinoma, Pancreas, Plasma cell dyscrasia

Case Report

Acinar cell carcinoma of pancreas is a rare epithelial tumor of pancreas.⁽¹⁾ It accounts only 1% of exocrine pancreatic tumors.⁽²⁾

Patients with acinar cell carcinoma of pancreas present in younger age, generally have resectable disease and their survival are significantly higher com-

pared with patients with pancreatic adenocarcinoma.⁽³⁾

There is only one report exists in literature regarding association between acinar cell carcinoma of pancreas and myeloma-like cast nephropathy.⁽⁴⁾ We want to present nephrotic range proteinuria and plasma cell dyscrasia in a case of acinar cell carcinoma of pancreas.

A 57 y/o male presented with hematemesis and malaise. He had history of low back pain. Upper gastrointestinal endoscopy revealed peptic ulcer disease (gastric ulcer and duodenal ulcer). Further work-up showed:

WBC=6400/ μ L, Hb=10.8 gr/dl, MCV=94 fL, Plt count=161'000/ μ l, Cr=1.5 mg/dl, BUN=18 mg/dl, ESR=90mm/hr and +3 proteinuria in Urine analysis, nephritic-range proteinuria in 24 hour urine(3800 mg/day), Albumin=2.9 gr/dl(NI: 4-4.8), monoclonal gammopathy in serum protein electrophoresis(Gamma=2.6 gr/dl, normal range: 0.8-1.4 g/dl), SGOT=62 U/L(NI<41), SGPT=65(NI<41), Total Bilirubin=6.98 mg/dl, Direct Bilirubin=5.71 mg/dl, Alkaline phosphatase=619U/L (NI:80-306), serologic tests were negative for HBS Ag, HCV Ab, ANA, Anti-ds DNA, C-ANCA, P-ANCA.

Abdominopelvic magnetic resonance imaging (MRI) showed a 8×5 Cm mass in right para-aortic area. Abdominal sonography revealed multiple hypoechoic heterogeneous lesions in porta hepatis and peripancreatic and para-aortic areas. Laparotomy and biopsy of para-aortic mass was done and pathological examination revealed: acinar cell carcinoma of pancreas. Bone marrow aspiration showed more than 40% plasma cells. Skull-X ray and lumbar X-rays revealed lytic lesions. The diagnosis of multiple myeloma was made according to raised number of plasma cells in bone marrow, monoclonal gammopathy and normocytic-normochromic anemia and elevated erythrocyte sedimentation rate and lytic lesions in skull&lumbar X-rays.

We found coexistence of acinar cell carcinoma of pancreas and plasma cell

dyscrasia in this patient with nephritic-range proteinuria. Renal biopsy was recommended a necessary tool for finding exact cause of nephrotic-range proteinuria.

Acinar cell carcinoma of pancreas is a rare type of pancreatic cancers. It accounts for only 1% of cancers that arise from exocrine portion of pancreas.⁽²⁾ It occurs generally in sixty to seventy years old patients and has a male predominance.^(5,7) It may be large and metastatic at presentation.

The typical presentations of Acinar cell carcinoma of pancreas are included subcutaneous fat necrosis, polyarthrits and eosinophilia (Schmid's triad) due to increased lipase secretion by this tumor.⁽⁶⁾

The usual initial manifestations are weight loss, abdominal pain, nausea and vomiting. Because it arise from the pancreatic acinar cells symptoms due to pancreatic enzymes (insulin, glucagon and insulin-like growth factors) secretion can be other manifestations of this tumor.⁽⁵⁾ Treatment protocols for acinar cell carcinoma of pancreas is not standardized due to rarity of this cancer.⁽⁷⁾

It may be an association between plasma cell dyscrasia and acinar cell carcinoma of pancreas. Same oncogenes or carcinogens may be involved in both diseases.

References:

1. Klipin M, Sparaco A, Omoshoro-Jones J, Smith MD: Acinar cell carcinoma-a rare tumour of the pancreas. *S Afr J Surg* 2008; 46: 88.
2. Virlos I, Papazachariou I, Williamson R: Acinar cell carcinoma of the pancreas with and without endocrine differentiation. *HPB (Oxford)* 2002; 4: 87-90.
3. Wisnoski NC, Townsend CM, Jr, Nealon WH, Freeman JL, Riall TS: 672 patients with acinar cell carcinoma of the pancreas: A population-based comparison to pancreatic

adenocarcinoma. *Surgery* 2008;144: 141-148.

4. Reducka K, Gardiner GW, Sweet J, Vandenbroucke A, Bear R: Myeloma-like cast nephropathy associated with acinar cell carcinoma of the pancreas. *Am J Nephrol* 1988; 8: 421-424.

5. Aqel B, Scolapio J, Nguyen J, Krishna M, Raimondo M. Recurrent pancreatitis due to a cystic pancreatic tumor: a rare presentation of acinar cell carcinoma. *JOP. J Pancreas (online)* 2004; 5:151-4.

6. Ashley SW, Lauwers GY. Case records of the Massachusetts General Hospital. Weekly clinicopathological exercises. Case 37-2002. A 69-year old man with painful cutaneous nodules, elevated lipase levels, and abnormal results on abdominal scanning. *N Engl J Med* 2002; 347: 1783-91.

7. Monique A, Marina K, Muhammad W. Long-Term Survival in a Patient with Acinar Cell Carcinoma of Pancreas. A Case Report and Review of Literature. *JOP. J pancreas(online)*2007; 8 (6): 783-789