



PANCREAS CYSTS: VIDEOLAPAROSCOPIC TREATMENT- CLINICAL CASES

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ABSTRACT

The authors present three patients who had a diagnosis of pancreatic tail cyst detected in the complementary exams. They performed resection of the cyst and part of the pancreas with video-laparoscopy. The surgery went without complication and was performed within a considered good time. The evolution was good, with little pain, rapid recovery and with minimal aggression to the abdominal wall, thus demonstrating its feasibility combined with the advantages of video-laparoscopy.

KEYWORDS: Pancreas cysts; therapeutic; videolaparoscopy.

INTRODUCTION

The pancreas cysts are infrequent. Its actual incidence is not well known, but we know that it constitutes 1% of all pancreatic neoplasms.^[1]

Until very recently they were indistinctly labeled as adenomas and adenocarcinomas, but from the analysis of the histological study of dried parts, it was possible to fit them into different categories.^[2]

Nowadays, due to the great use of ultrasound examinations, the incidental finding of pancreas cyst has become more frequent and its treatment discussed early can reduce the number of complications and degeneration.^[3] Thus, the importance in its early recognition is linked to treatment that should always be surgical including pancreatectomy with or without splenectomy. This procedure is performed by broad laparotomy usually followed by moderate degree of morbidity, discomfort, and pain; However, the result is good.^[4]

As an advent of video-laparoscopy, the procedure was proposed and performed in an attempt to reduce the degree of aggression to the abdominal wall, thus minimizing patient suffering.

It is our aim to present three patients with a diagnosis of cysts in the region of the tail of the pancreas and who were resected with the aid of video-laparoscopy, with the purpose of demonstrating that the technique is feasible to

be applied by this route and with advantages already known from video-surgery.

Clinical Cases

Case 1

L.V.V., 40 years old, female, brown.

Patient Quality: Colic and pain episodes in the upper abdomen.

In July 1997, after an ultrasound examination, vesicular lithiasis and pancreatic cyst were diagnosed. In the computed tomography examination, there was confirmation of vesicular and cystic lithiasis located in the tail of the pancreas measuring 6 x 5 cm in diameter.

The surgery was performed in September, 1997 and constituted cholecystectomy and caudal pancreatectomy by video-laparoscopy and splenectomy.

The evolution was uncomplicated and remained hospitalized for 5 days.

Histopathological examination - Chronic cholecystitis and simple pancreas cyst.

Case 2

V.M.M., 26 years old, female, white.

A pregnant patient. When performing an ultrasound examination, a cyst was diagnosed in the tail of the pancreas measuring 8 x 5 cm in diameter. Surgery after childbirth was recommended.

Surgery of caudal pancreatectomy with removal of the cyst and splenectomy.

Histopathological examination - Simple pancreas cyst with normal pancreas fragment and suprarenal tissue fragment.

Case 3

M.M.T., 37 years old, female, white.

When performing an ultrasound study for gynecological evaluation, a cyst in the tail of the pancreas of 5 x 4 cm was diagnosed. Surgery was recommended, but the lack of symptoms preferred to wait. After 1 year of diagnosis, the patient returned for a new evaluation. There was a slight increase of the cyst with presence of septa inside the cyst and surgery was recommended.

Surgery: caudal pancreatectomy with removal of the cyst.

Histopathological examination: pancreas mucinous adenoma cyst and chronic pancreatitis with fibrosis.

DISCUSSION

The pancreas cysts do not present a well-known incidence since most of them are symptomatic or are oligosymptomatic, however, we know that they are 10% of all cystic tumors of the pancreas. The incidence is higher in women over 20 years and with a mean of 54 years.^[5,6] In two-thirds of cases, they are located in the body and tail of the pancreas as was also observed in our cases.

Its diagnosis is initially made through complementary tests performed for other purposes such as upper abdominal ultrasound or computed tomography. As was also observed in our 3 cases.

Differential diagnosis should be made with pancreas pseudocysts and is not difficult to establish especially in patients with pseudocyst secondary to pancreatitis outbreak with an elevation of amylase and the presence of calcifications detected in the simple X-ray of the abdomen. Pseudocysts are often multiple.^[7]

In the macroscopic examination of the pancreas with true cysts, we can observe that the structure of the remaining pancreas is preserved in contrast to what we observed in the pseudocysts.

Although all the possibilities of differential diagnosis have been evaluated and if there are still doubts about the true diagnosis, it is recommended to consider as being of a true cyst, preferring to perform the resection without running the risk of making a true cyst.

Among the pancreas cystic lesions, cystoadenomucinos and cystoadenocarcinomas are the most commonly found lesions, but the final histopathological diagnosis is not

always easy to establish because the same cyst there may coexist fragments of normal tissue with neoplastic tissue.^[8]

The pancreas cysts due to of the impossibility of establishing a certain diagnosis, and in the face of progress with surgical treatment and potential cure, should preferably be treated by pancreatic resection. So when the cysts are located in the head of the pancreas we must perform the Whipple operation and when located in the tail or body the distal pancreatectomy as was what occurred in our three cases.^[9]

CONCLUSION

The Whipple operation, although it is possible to be performed by video-laparoscopy, still requires more observations, as it does not seem to offer advantages over the open path.

Conflict of Interests

The authors declare that there is no conflict of interests regarding the publication of this manuscript.

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