

Liver and Pancreatic Case discussion

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77 year old gentleman with 2 months' history of vague abdominal ache and clinically finding of upper abdominal mass. What would you do?

- 1) Routine ultrasound of abdomen
- 2) Urgent ultrasound abdomen within 2 weeks
- 3) Urgent CT scan of abdomen and pelvis within 2 weeks
- 4) Urgent suspected cancer referral to local gastroenterology service
- 5) Others



NICE Guidance 2015

Suspected cancer: recognition and referral

Gall bladder cancer

1.2.10 Consider an urgent direct access ultrasound scan (to be performed within 2 weeks) to assess for gall bladder cancer in people with an upper abdominal mass consistent with an enlarged gall bladder. [new 2015]

Liver cancer

1.2.11 Consider an urgent direct access ultrasound scan (to be performed within 2 weeks) to assess for liver cancer in people with an upper abdominal mass consistent with an enlarged liver. [new 2015]



Case history 1

- 77 years old male
- Presented in 2012 with abnormal liver function tests during routine statin review
- US showed fatty liver only
- Patient was drinking 40 units of alcohol per week, but promised to cut down
- 2014 Haematemesis Upper GI endoscopy showed oesophageal varices
- Repeat ultrasound showed irregular liver, 13cm spleen, no liver lesions
- Only drinking 5 units of alcohol per week



What further follow up would you recommend?

Follow-up A: regular surveillance ultrasound

Follow-up B: regular serum alpha fetoprotein

Follow-up C: specialist hepatology follow up

Follow-up D: GP follow-up (under guidance from local hepatologist)

A. A and C

B. A, B and C

C. B and C

D. A, B and D

E. All of the above

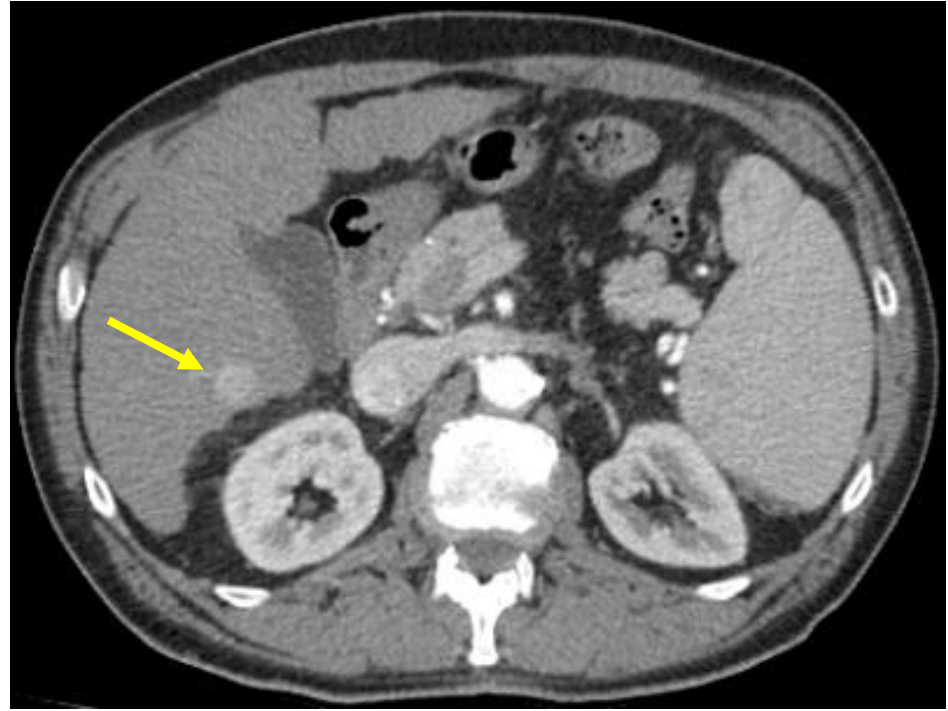
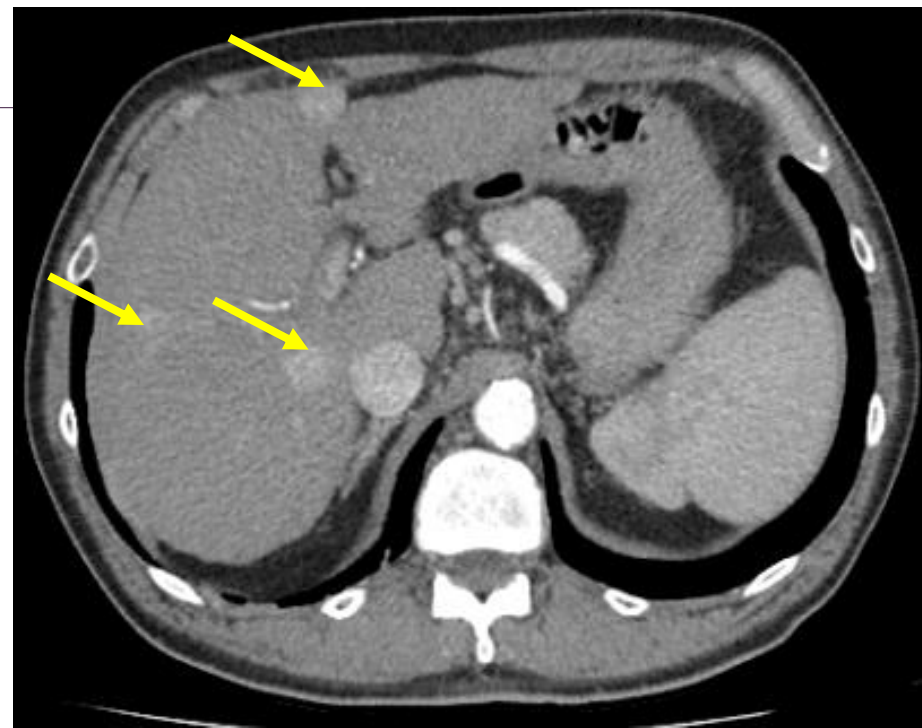
F. Others

Case history 1 (cont'd)

- Jan 2015 US showed 1.4cm hypoechoic lesion distorting liver capsule
- Feb 2015 CT confirmed 12mm enhancing lesion suggesting possible HCC or solitary metastasis
- Patient lost to follow up
- Oct 2015 Patient re-attended for repeat CT and MRI scans



Multiple arterially enhancing lesions in liver

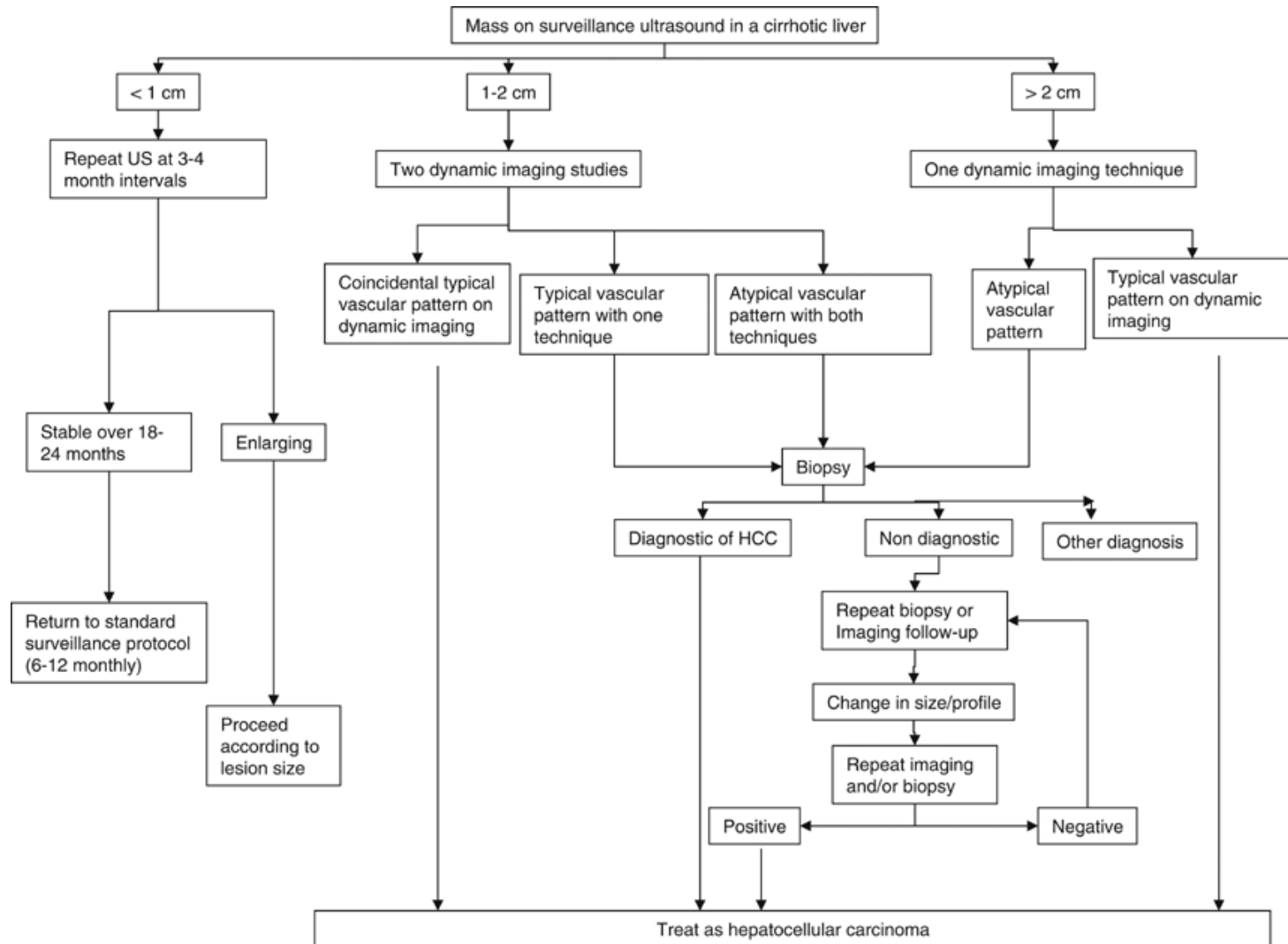


AFP = 8

Contrast-enhanced MRI showed at least 7 lesions scattered throughout both lobes of the liver measuring up to 23 mm in size



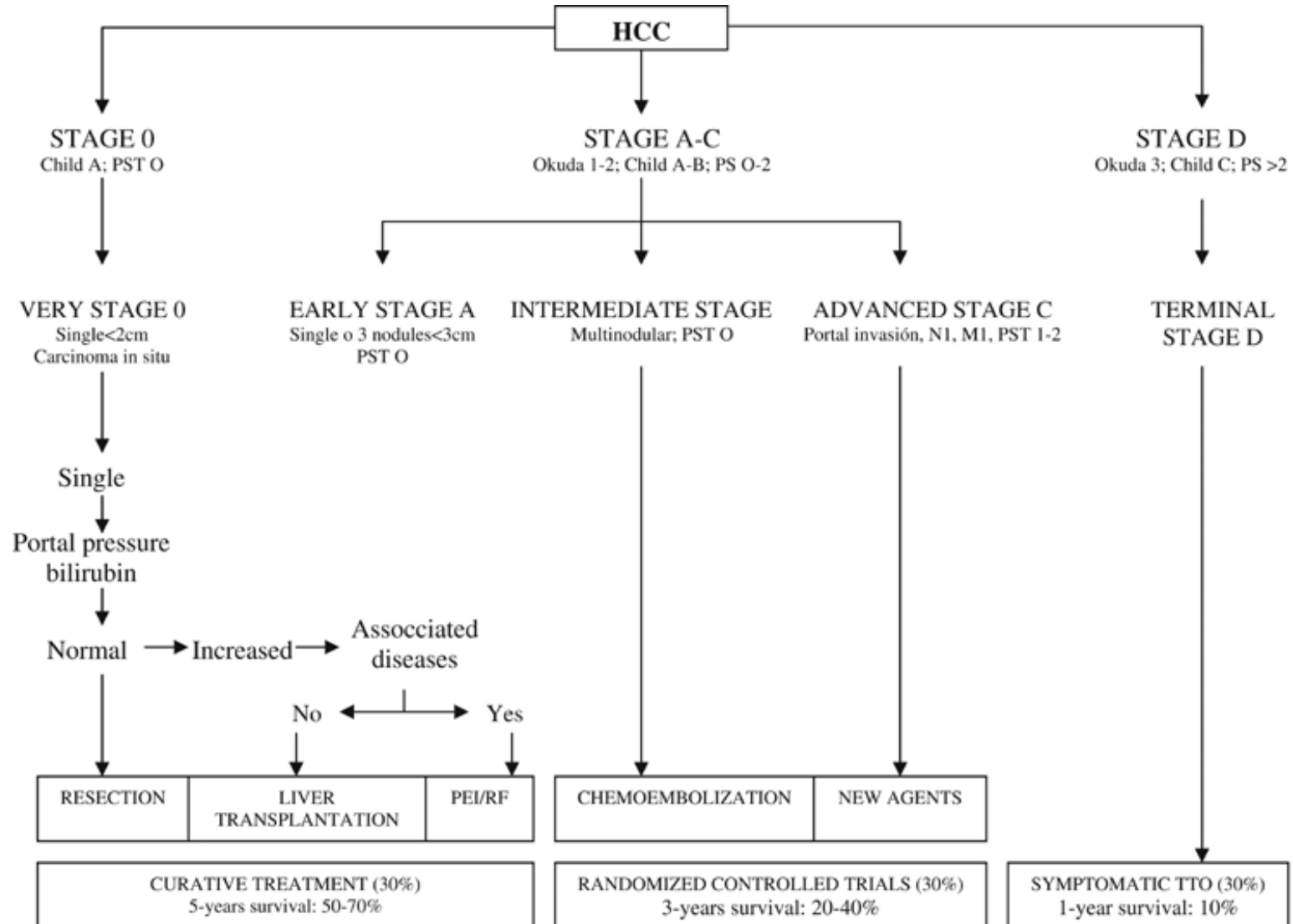
Diagnosis of HCC



What treatment would you recommend?

- A. Liver transplantation
- B. Liver resection
- C. Transarterial
(chemo)embolisation
- D. Radiofrequency or
microave ablation
- E. Systemic therapy with
sorafenib
- F. No treatment -
palliative care alone

Management of HCC

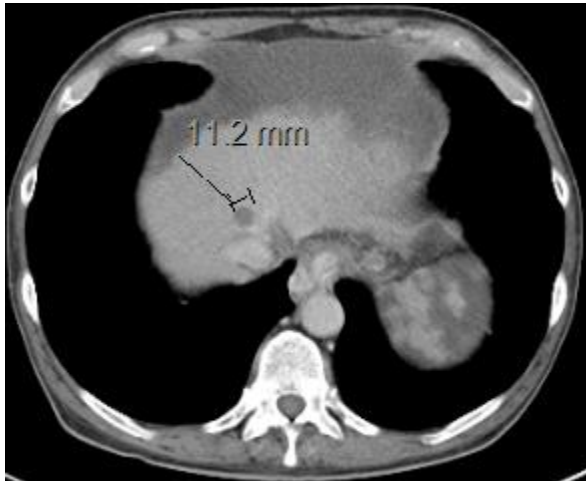
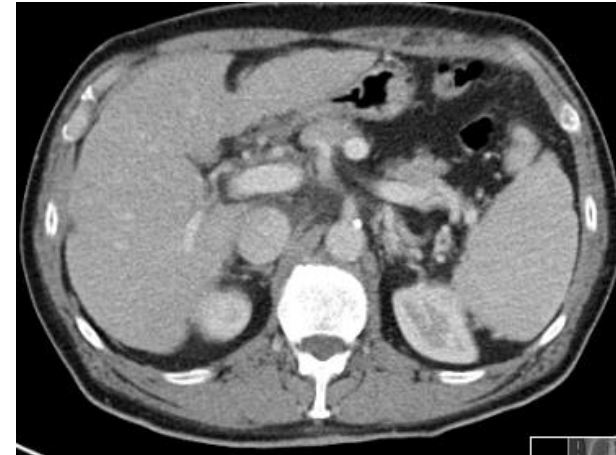
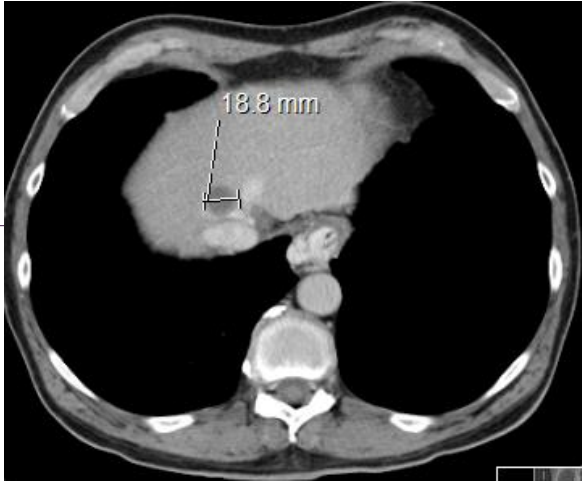


Case history 1 (cont'd)

- Jan 16 Patient had transarterial embolisation



December 2015 Pre-embolisation



February 2016 Post-embolisation

Case history 1 (cont'd)

- Jan 16 Patient had transarterial embolisation
- Post-embolisation CT showed progressive cirrhosis, ascites, diminution of liver and spleen with changes suggestive of liquefaction of spleen and pancreatic tail
- Fortunately patient remained clinically well and no deterioration of LFT
- Discussed at MDT → no further transarterial embolisation in the future



Where do you think this patient should be followed up?

- A. Medical oncology clinic
- B. General practice
- C. Local hepatology clinic



The following would prompt you to ask for an urgent suspected cancer referral for pancreatic cancer in a 52 years old woman:

Symptom A: Jaundice with epigastric pain

Symptom B: Hip Pain

Scenario C: Routine ultrasound for mildly deranged LFT shows a cystic lesion in the body of pancreas

Symptom D: Unexplained weight loss

- A. A and C
- B. A, B and C
- C. A, C and D
- D. A and D
- E. All of the above

Case 2

- 52 year old female
- Presented with jaundice, RUQ pain, pale stools and dark urine
- No significant weight loss
- PS =1
- Liver function test revealed bilirubin of 96 and Alkaline phosphatase of 470
- Family history quite remarkable as she is a carrier of HLRCC (hereditary leiomyomatosis and renal cell cancer).
- This condition is inherited in autosomal dominant pattern and has been reported in approximately 100 families worldwide. HLRCC is usually characterised by cutaneous leiomyomata, uterine leiomyomata and/or renal tumour. Her brother died of renal cell carcinoma at 36. Her sister died of renal cell carcinoma at 40, and her son Jack underwent a nephrectomy for renal cell carcinoma at 11 years. Both of her parents are still alive and her mother is in a psychiatric hospital.



What investigation would you like to perform?

- A. Ultrasound of liver
- B. CT scan of abdomen
- C. Hepatitis serology
- D. Other tests
- E. No tests, refer directly to hospital A &E

Case 2

- 52 years old female
- Presented with jaundice, RUQ pain, pale stools and dark urine
- No significant weight loss
- PS =1
- Liver function test revealed bilirubin of 96 and Alkaline phosphatase of 470
- Referred directly into hospital via A&E
- US liver → dilated biliary ducts
- MRCP → Common bile duct and intrahepatic duct slightly dilated ? Ampullary obstructing tumour
- CT → pancreas appears normal



What would be the next plan of management?

- A. ERCP and plastic biliary stent insertion
- B. ERCP and metal biliary stent insertion
- C. Refer to surgeon for a pylorus-preserving pancreaticoduodenectomy for possible ampullary tumour

Case 2

- 52 years old female
- Apr 2014 Presented with jaundice, RUQ pain, pale stools and dark urine
- No significant weight loss
- PS =1
- Liver function test revealed bilirubin of 96 and Alkaline phosphatase of 470
- Referred directly into hospital via A&E
- US liver → dilated biliary ducts
- MRCP → Common bile duct and intrahepatic duct slightly dilated ? Ampullary obstructing tumour
- CT → pancreas appears normal
- May 2014 ERCP → plastic stent inserted. Biliary brushing negative
- Patient discharged home

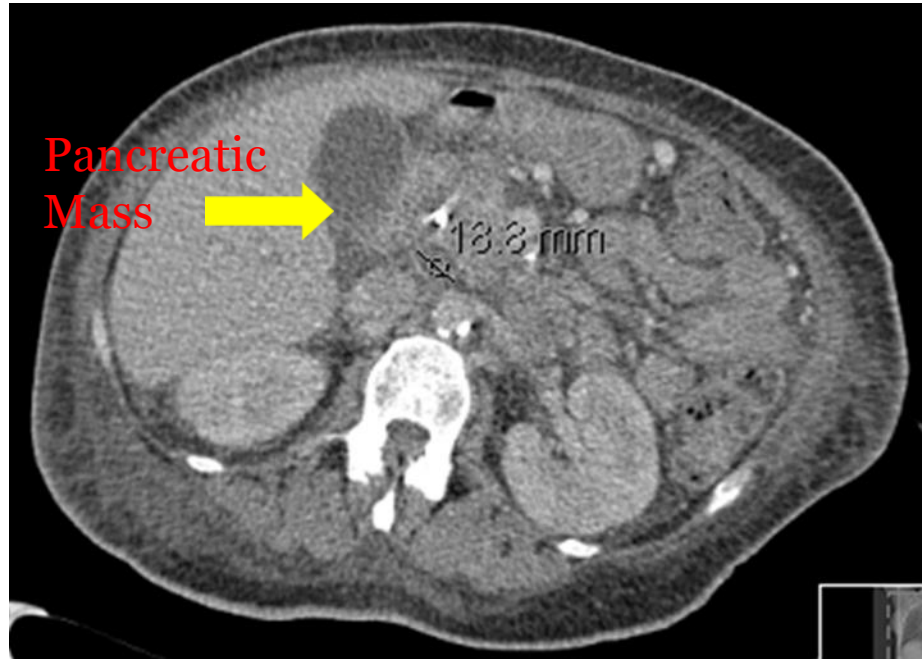


How should this patient be followed up?



Case 2

- 20 November 2014 presented with pyrexia, jaundice and vomiting
- CT →



Case 2

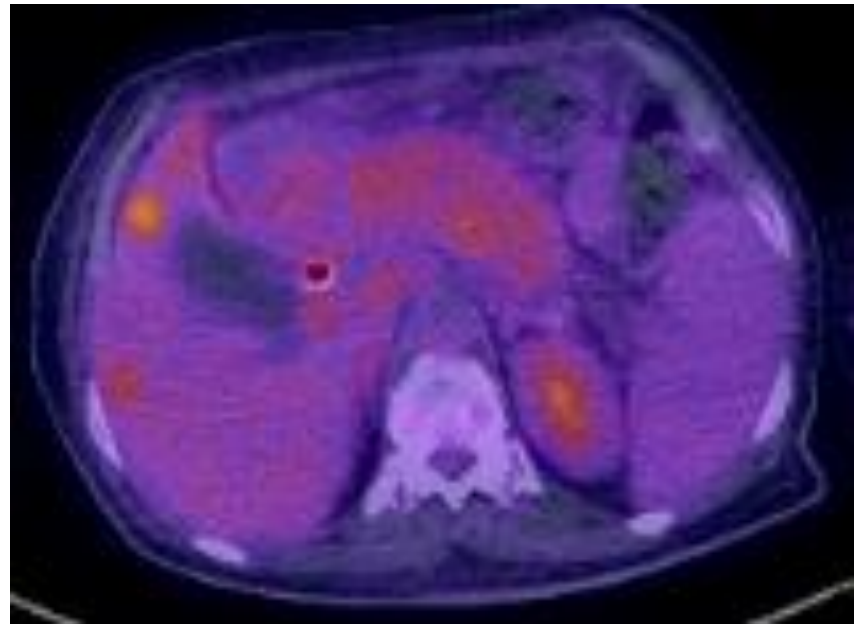
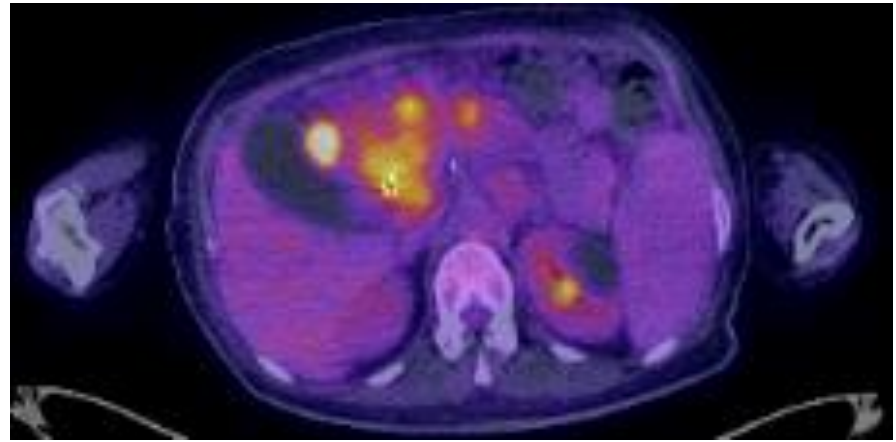
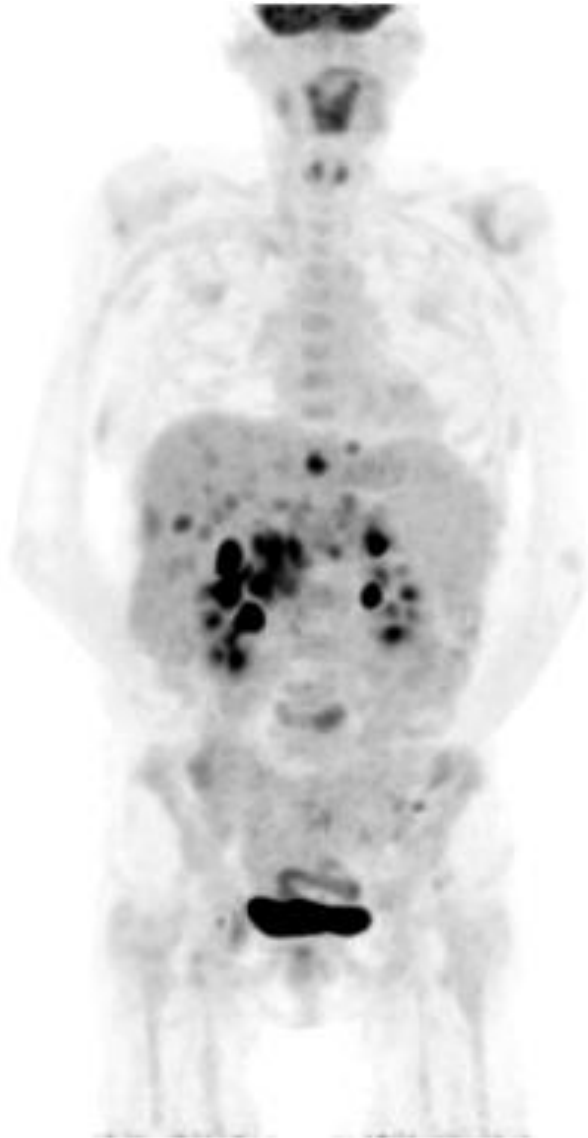
- 20 November 2014 presented with pyrexia, jaundice and vomiting
- CT →
- Developed septic shock from *Klebsiella pneumoniae*
- ITU admission, intubation and multi-organ support
- ECHO (3rd December 2014) vegetation on the mitral valve suggestive of bacterial endocarditis
- Sepsis thought to be secondary to blocked biliary stent
- Repeat ERCP (5-12-14) and further biliary brushing → adenocarcinoma



What would be the next plan of management?

- A. Consideration of pancreatic surgery
- B. Consideration of mitral valve replacement
- C. No surgery, palliative chemotherapy
- D. No surgery or palliative chemotherapy; for symptom control only

January 2015



Case 3

- 78 years old female
- 2007 intermittent abdominal discomfort with fevers
- Underwent pelvic floor repair in 2007 and further investigations for abdominal pain
- Found to have abnormal LFT – Alkaline phosphatase = 140
- MRI liver – primary sclerosing cholangitis
- Started on ursodoxycholic acid
- PMH: cholecystectomy, hysterectomy, hypertension



What monitoring do you think is required?

- A. Regular serial liver functions
- B. Regular MRI liver
- C. Regular colonoscopy
- D. All of the above
- E. None of the above
- F. Others

Case 3

- For last 7 years, serum alkaline phosphatase between 150-170
- January-March 2015, went on a 10 weeks' cruise.
- Developed cough and right upper quadrant pain
- On return back to the UK, persistent cough and RUQ pain



What would be your next plan of management?

- A. CXR
- B. Liver function test
- C. Ultrasound of liver
- D. MRI liver
- E. Refer back to the treating gastroenterologist for her primary sclerosing cholangitis
- F. All of the above
- G. None of the above

Case 3

Abnormal LFT – alkaline phosphatase ↑ to 267

US → 4 cm lesion in liver

Referred back to gastroenterologist

MRI showed necrotic mass lesion in segment 8 of the liver



What is the most likely diagnosis?

- A. Liver abscess
- B. Hepatocellular carcinoma
- C. Cholangiocarcinoma
- D. Liver metastasis from another primary tumour
- E. Others

Serum CA19-9 is elevated at 735 (Normal range <35iu/L). What investigation will be required?

- 1) CT scan
- 2) Dedicated cholangiocarcinoma protocol MRI
- 3) PET/CT
- 4) US/CT-guided liver biopsy of the necrotic lesion



Case 4

- 46 years old female
- Jan 2017 presented with neck and right arm pain for seven months
- Pain progressive worse and developed one week onset of right arm weakness and numbness

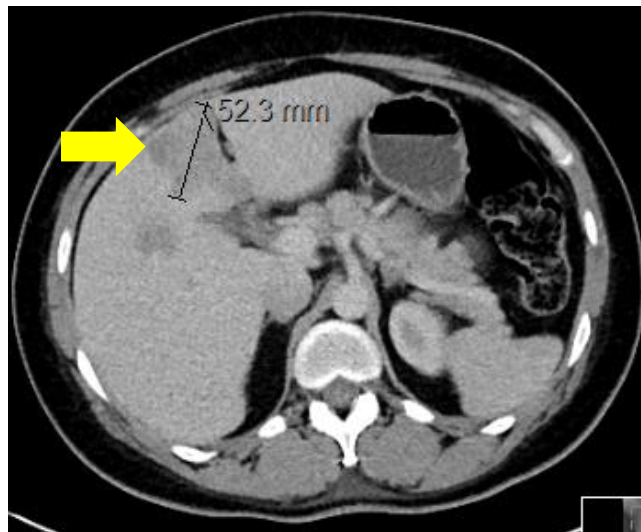
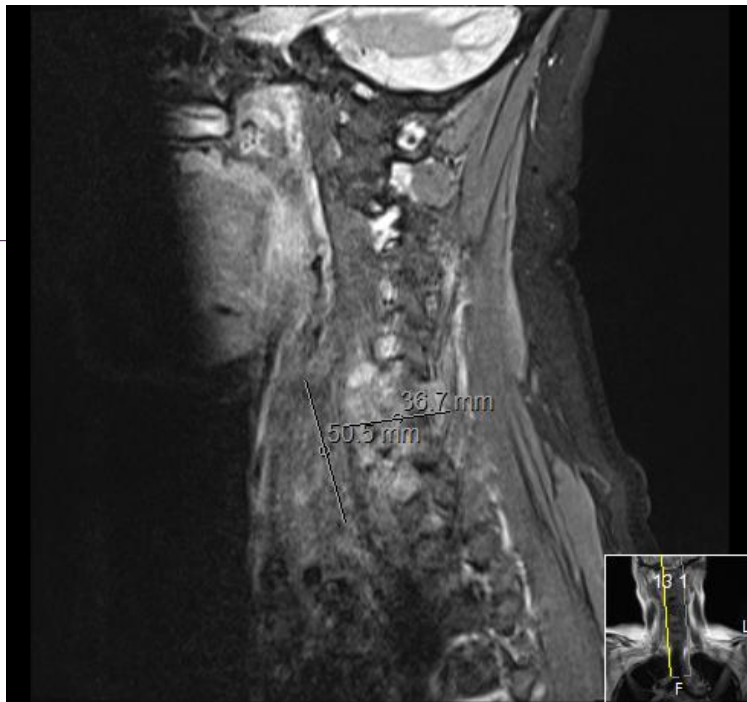


What would be your next plan of management?

- 1) CXR
- 2) Liver function test
- 3) Ultrasound of abdomen
- 4) Cervical spine X-ray
- 5) Urgent MRI
- 6) Urgent referral to specialist
- 7) All of the above
- 8) None of the above



January 2017

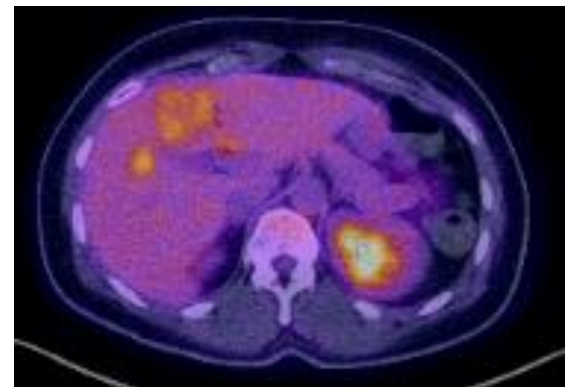
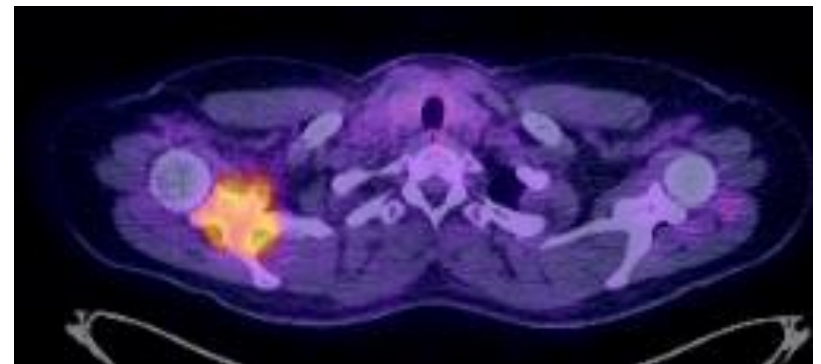
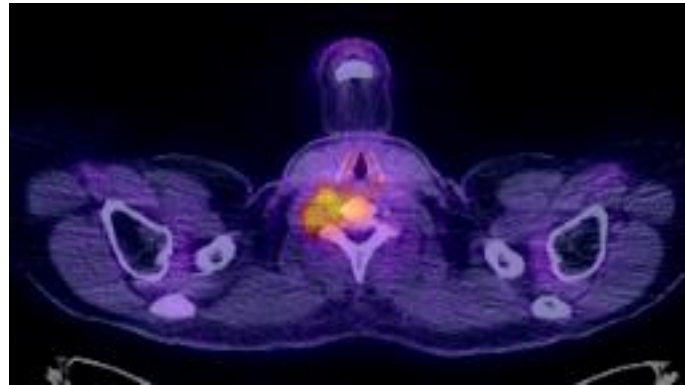


Case 4 (cont'd)

- 46 years old female
- Jan 2017 presented with neck and right arm pain for seven months
- Pain progressive worse and developed one week onset of right arm weakness and numbness
- CT and MRI showed mass on the right C5/C6 neural foramen with extension into the spinal canal but no spinal cord compression
- Discussed in neurosurgical MDM but advice was for radiotherapy
- Biopsy of the mass showed adenocarcinoma
- Radiotherapy 10th - 15th February 2017 to C4 to T1



February 2017



Case 4 (cont'd)

- Discussed at Unknown Primary MDT meeting
- Thought the histology consistent with gallbladder primary with distant metastases
- To assess for fitness in medical oncology clinic for systemic chemotherapy
- Mar 2017 seen at medical oncology clinic
- Current in-patient at hospice for pain control after radiotherapy
- Wished to stay in hospice for the first month of chemotherapy
- Social history: single mother, two daughters 24 and 12 years old
- “Will speak to my GP to sort things out”



How do you sort things out??

