

CLINICAL VIGNETTE

A Challenging Diagnosis of Pancreatic Cancer

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Case

A 79-year-old man presents to primary care with new epigastric pain. His PMHX includes CAD s/p 3-vessel CABG, cerebral vascular accident (CVA) and remote tobacco use, (40 years ago). He reports waves of sharp epigastric pain over the past two days unrelated to food intake. The pain is worse at bedtime, does not radiate, and has mild constipation. Prior to symptom onset, he ate unrefrigerated cheese, and also reports bloating, with concerns for a bacterial infection. He has lost 10 pounds over 6 months which is attributed to recovering from right hip arthroplasty 12 weeks prior. His abdominal exam is benign with no reproducible pain. Pertinent labs include WBC 12.58 (4.5 to $11.0 \times 10^9/L$), absolute neutrophil count 9.12 (1,500 to 8,000/mm³), CRP 11.5 (0.3 mg/dL). Given concern for possible bacterial etiology, empiric metronidazole and sucralfate are prescribed.

He also establishes care with a gastroenterologist two weeks later and reports some improvement in pain. Sucralfate is discontinued and Omeprazole is prescribed. He is scheduled for colonoscopy and EGD. Four weeks after initial presentation, he returns to his PCP and reports general improvement in his epigastric pain. However, he did note two shorter, less severe pain episodes in the week prior to his visit. He also reports generalized anxiety and is Hydroxyzine.

Eight weeks after his initial presentation, the colonoscopy and EGD are completed, with no remarkable findings and CT abdomen with and without contrast is scheduled. At his PCP follow up, he reports decreased frequency and duration of his pain attributed to Omeprazole Labs include HAlc increased from 5.8 to 6.1 in the past 6 months. A few days later, he reports new onset of jaundice, and the CT abdomen is expedited to urgent. It shows a 2 cm mass in the head of the pancreas, which is confirmed as pancreatic adenocarcinoma on biopsy.

Discussion

Abdominal pain is a common complaint and accounts for 5-10% of all emergency department visits.¹ Imaging should be considered if patients' pain is unresolved. The American College of Radiology ACR Appropriateness Criteria guide clinical decision-making. The criteria include pain location and presence of fever or neutropenia. This patient had no fever or neutropenia and CT or MRI is categorized as "usually appropriate." The algorithm for generalized abdominal pain by Vaghef-Davari et al, recommends that patients with no

guarding, without pulsatile mass or suspicion for aortic aneurysm initially consider abdominal and chest radiographs as well as labs (CBC, CMP, Amylase).² If initial radiographs show no signs of obstruction, or have no definitive diagnosis, CT abdomen is recommended.³

This case highlights challenges in diagnosing pancreatic cancer. The rarity of this cancer with 1% lifetime risk in the general population suggests that the average primary care physician rarely encounters this diagnosis once every few years.⁴ A retrospective study reported that the average patient with pancreatic cancer sought medical attention 18 times in the period preceding their pancreatic cancer diagnosis.⁴ Primary care physicians evaluating patients with recurrent abdominal pain may benefit by reviewing the imaging algorithms from the American College of Radiology reporting. New diabetes illness has been found in up to 50% of patients with pancreatic adenocarcinoma.⁵

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