US-GUIDED BIOPSY OF ABDOMINAL WALL LESIONS

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MS4
66 YOF with hx of pancreatic adenocarcinoma Stage IIb T3N1cM0

Underwent surgical resection in 2015 with a Whipple

She had adjuvant chemoradiation during the time of resection, but was found to have local recurrence in May 2017 and started on gemcitabine

Recently, she reports 8 months of progressive N/V and fevers and chills for the past 2 weeks and jaundice

MRI demonstrated obstruction of her biliopancreatic limb at the level of the transverse mesocolon, with concern that the obstruction developed as a result of recurrence at the root of the mesentery

Labs demonstrated bilirubin of 5.5 and she received a PTBD from IR. Abdominal CT was done which showed 2.5cm x 1.5cm focal nodule along previous midline incision. Body procedures was consulted to biopsy the mass and determine if it represented malignancy
PRE-PROCEDURE CT ABDOMEN
DIFFERENTIAL DIAGNOSIS

- Recurrence of pancreatic adenocarcinoma with metastatic focus
- Endometriosis
- Lipoma
- Desmoid tumor
- Lymphoma
- Hematoma
- Epidermoid cyst

Example US of metastasis
Ultrasound is considered the first-line modality for image-guided procedures on abdominal wall masses

- Advantages: live imaging, no ionizing radiation, portable
- Lesions as small as one centimeter can be accurately biopsied
- US characteristics of mass can give insight into diagnosis if only available imaging of lesion is cross-sectional
- At the top of ddx is metastatic pancreatic adenocarcinoma, so core bx will give us tissue architecture to help make our diagnosis
Poorly defined, variably hypoechoic mass with aberrant vasculature, no posterior shadowing or calcification
One of the pathologist’s greatest assets in a case with previous hx of cancer is previous path results (shown on right for our patient)

Able to compare tissue architecture (i.e. met will likely be well-differentiated if primary was also - the caveat being time between diagnosis of primary and biopsy of met)
PATH RESULTS

- Two FNA passes with 25G and 22G needles contained adequate cellular material but were insufficient for definitive characterization, so ultimately 16G core biopsy was performed.

- Result of core bx is well-differentiated pancreatic adenocarcinoma, with glandular tissue clearly identified.
FINAL CONSIDERATIONS

- Worries about needle tract seeding
  - Using doppler, we avoid vasculature that could carry dislodged malignant cells to distant sites
  - More of a concern for visceral malignancies where needle tract during biopsy is long (our lesion was superficial)
  - Highest risk is during breast cx biopsy
- In our case, the original surgical resection resulted in tract seeding, so perhaps this cancer is molecularly higher risk for tract seeding
