Cystic gastrointestinal stromal tumors of the pancreas simulating cystoadenocarcinoma. Report of three cases and short review of the literature

M.R. Ambrosio¹, B.J. Rocca¹, M.G. Mastrogiulio¹, A. Pesci², A. De Martino³, M.A. Mazzei³, L. Volterrani³, F. Arcuri³, M. Cintorino³ and S.A. Tripodi⁵

¹Department of Medical Biotechnologies, University of Siena, ²Ospedale Sacro Cuore, Verona, ³Department of Medical Sciences, Surgery and Neurosciences, University of Siena, ⁴Department of Molecular and Developmental Medicine, University of Siena and ⁵Azienda Ospedaliera Universitaria Senese, Siena, Italy

Summary. Gastrointestinal stromal tumors (GISTs) represent a distinct subset of mesenchymal tumours of the gastrointestinal tract. They are more common in the stomach and small intestine, and are characterized by the proliferation of spindle or epithelioid cells and by the expression of CD117. Extra-gastrointestinal stromal tumors are rare and only 13 cases of pancreatic GISTs have been reported in the literature, only 1 of which presented as a cystic lesion. Mutational analysis of KIT and Platelet derived growth factor receptor-α genes was performed only in two out of the 13 cases.

We report 3 cases of cystic GISTs of the pancreas, radiologically mimicking a cystoadenocarcinoma. Routine histopathology and molecular characterization of the tumours have been performed. In two of them, molecular analysis showed unusual genetic alterations (the internal repeat of codon 502 and 503 in exon 9 of the KIT gene and the KIT exon 9 single nucleotide substitution c.1427G>T).

Pancreatic GIST should be included in the differential diagnosis of both cystic and solid masses of the pancreas. The diagnosis should be accomplished by a combination of radiology, histology, immunohistochemistry and molecular biology. The evaluation of CD117 expression and the sequence analysis of KIT and Platelet derived growth factor receptor-α gene is mandatory for therapy.

Key words: Pancreas, GIST, Extra-gastrointestinal stromal tumour, Cystic neoplasm, CD117

Introduction

Gastrointestinal stromal tumors (GISTs) represent a distinct subset of mesenchymal tumours of the gastrointestinal tract (Fletcher et al., 2002). They are characterized by the proliferation of spindle or epithelioid, occasionally pleomorphic, cells and by the immunohistochemical expression of KIT (CD117) (Hou et al., 2004). Mutation of KIT leads to the constitutional activation of tyrosine kinase activity, which is responsible for cellular proliferation and resistance to apoptosis (Moskaluk et al., 1999; Morey et al., 2002).

GISTs, which include most tumours previously classified as gastric or intestinal smooth muscle tumours, typically present in adults over 40 years (median age 55-60 years) and only exceptionally in children. The great majority of GISTs occur in the stomach (60-70%) and small intestine (25-35%) whereas oesophagus, colon, appendix and anus are rarely affected (Gharibo et al., 2008). Sometimes GISTs may affect omentum, mesentery, retroperitoneum, prostate and gallbladder; these tumors have been defined as “extra-gastrointestinal stromal tumors” (EGISTs) (Graadt van Roggen et al., 2001). Only 13 cases of pancreatic GISTs have been reported in the literature (Neto et al., 2004; Yamaura et al., 2004; Daum et al., 2005; Krksa et al., 2005; Showalter et al., 2008; Yan et al., 2008; Harindhanavudhi et al., 2009; Trabelsi et al., 2009; Padhi et al., 2010; Saif et al., 2010; Rao et al., 2011).
Cecka et al., 2011; Vij et al., 2011). Only one of them presented as a cystic lesion (Harindhanavudhi et al., 2009) and only in two cases mutational analysis of KIT and Platelet derived growth factor-α (PDGFR-α) genes was performed, finding a deletion of six base pairs in exon 11 of KIT gene in one case and a polymorphism of L862L in exon-18 of KIT gene in the other one (Daum et al., 2005; Saif et al., 2010).

Herein we report three cases of pancreatic GIST, macroscopically presenting as a large cystic mass and simulating a cystic pancreatic neoplasm. Following molecular characterization, two unusual mutations (the internal repeat of codon 502 and 503 in exon 9 of the KIT gene and the KIT exon 9 single nucleotide substitution c.1427G>T), previously described only in gastrointestinal GISTs, were found. A short review of the literature is included.

Material and methods

Cases report

Case 1. A 72 year-old man presented with upper abdominal discomfort, pain and dyspnoea. On physical examination, a palpable indolent abdominal mass was found. No jaundice was present. Laboratory data revealed only elevation of Ca-125. Abdominal ultrasonography (US) and contrast-enhanced computed tomography (CT) evidenced a 180x135 mm cystic lesion of the pancreas head with an irregular thick-wall and intense enhancement, suspicious for pancreatic cystic adenocarcinoma (Fig. 1A,B). There was neither retroperitoneal pathological lymphadenopathy nor ascitic fluid or hepatic metastases. On surgery, a cystic mass filling the epiploon retrocavity, and displacing the stomach and the omentum was found. The cyst originated from the pancreatic head; its anterior wall was easily separated from the omentum while it was partially adherent to the posterior wall of the stomach. Two months later, the patient presented with an important loss of weight (5 Kg), thus an abdominal CT scan was carried out. The analysis was performed by PCR amplification followed by direct sequencing of both the forward and the reverse strands with an ABI 310 Genetic Analyzer (Applied Biosystems, Foster city, CA, USA). Whole body CT-scan demonstrated a 7-cm cystic mass originating in the pancreatic body characterized by intracystic hyperechoic debris. CT-scan showed a cystic lesion with low-density values in the central part and strong enhancement in the arterial phase. The surrounding parenchyma showed signs of involution. No dilatation of the biliary and pancreatic ducts was observed. Duodenum was displaced by expansion of the tumour. Eighteen months later, a complete remission has been obtained.

Methods

The specimens were fixed in 10% buffered formalin and embedded in paraffin. From each block, tissue sections (4-µm thick) were obtained and stained with hematoxylin-eosin. Immunohistochemical stainings were employed by the Leica BOND-III fully automated system (Leica Biosystem, Milan - Italy) and using the Ultravision Detection System Anti-Polyvalent HRP (LabVision, Fremont, CA, USA) and diaminobenzidine (DAB, Dako-Milan, Italy) as chromogen. The following antibodies were checked: CD117 (clone T595, dilution 1:50), smooth muscle actin (SMA) (clone asm-1, dilution 1:100), cytokeratin AE1/AE3 (clone AE1/AE3, dilution 1:100), Ki-67 (clone K2, dilution 1:100), and CD34 (clone QBend/10), desmin (clone DE-R-11), vimentin (clone SRL33), DOG-1 (clone K-9), S-100 (polyclonal), chromogranin (clone 5H7), synaptophysin (clone 27G12), Neurope specific enolase (NSE) (clone 22C9), all ready to use. The antibodies were all purchased by Novocastra (Leica Biosystem, Milan - Italy). Sequence analysis of kit exons 9, 11, 13 and 17 as well as PDGFR-α exons 12 and 18 was also carried out. The analysis was performed by PCR amplification followed by direct sequencing of both the forward and the reverse strands with an ABI 310 Genetic Analyzer (Applied Biosystems, Foster city, CA, USA).

Results

In all the three cases a classic Whipple pancreaticoduodenectomy was performed and the surgical specimen consisted of pancreatic head and body, duodenum, gallbladder and antrum. Case 1. On macroscopic examination a 19x14x12 cm tumour was found in the head of the pancreas. The distance from the pancreatic resection margin was less than 1 mm. The tumour was cystic exhibiting a firm whitish 3-cm thick wall and showing yellowish papillary projections into the cystic cavity. The lumen contained a dark liquid. The lesion was well demarcated by pancreatic parenchyma but seemed to infiltrate focally the gastric wall. Histologically the tumour showed both...
Three cases of cystic gastrointestinal stromal tumors of the pancreas

Fig. 1. CT scan showing a 180x135 mm cystic lesion (A-B), histologically composed by epithelioid and spindle cells (C) positive to CD117 (D) and DOG-1 (E) with a proliferative index of 30% (E, bottom left). DNA sequencing identified the single nucleotide substitution (c.1427G>T) (F). C, haematoxylin and eosin (H&E). C-E, x 20
Three cases of cystic gastrointestinal stromal tumors of the pancreas

Fig. 2. On surgery, a 7x4 cm cystic lesion replacing the head of the pancreas was observed (A-B). Histologically the tumour consisted of spindle cells with plump nuclei (C) positive to CD117 (D) and DOG-1 (E). DNA sequencing showed a deletion of 4 pairs in exon 11 of KIT (F). C, H&E. C-E, x 20
Three cases of cystic gastrointestinal stromal tumors of the pancreas

Fig. 3. Macroscopically a yellowish mass in the pancreatic body was observed (A-B), which was composed of spindle-shaped cells in a fascicular arrangement (C), expressing CD117 (D) and DOG-1 (E). DNA sequencing revealed an internal tandem repeat codon of 502 and 503 in exon 9 of KIT gene (F). C, H&E. C-E, x 20
diffuse epithelioid and spindle cells in a thin reticular framework (Fig. 1C). Epithelioid cells formed thick digitations in the lumen simulating a papillary pattern, whereas spindle cells showed a fascicular or storiform arrangement. No skeinoid fibres were seen. Mild nuclear atypia and focal cytoplasmatic vacuolization were present as well as areas of coagulative necrosis. Mitotic index was >5 mitoses/50 high-power fields (HPF). The neoplastic cells were separated from the pancreatic parenchyma by a thick fibrous capsule. Immunohistochemical analysis revealed positivity of the neoplastic cells for CD117 (Fig. 1D) and DOG-1 (Fig. 1E). CD34 expression was also strong and diffuse. Vimentin and S-100 expression was also strong and diffuse. Vimentin and S-100 cells for CD117 (Fig. 1D) and DOG-1 (Fig. 1E). CD34 was >5 mitoses/50 high-power fields (HPF). The proliferative index (Ki-67) was about 30% (Fig. 1E, bottom left). Sequencing of tumour tissue DNA identified the leading to a Ser476Ile aminoacidic change (Fig. 1F). The morphology and the immunohistochemical features indicated the diagnosis of GIST. The tumour was reported as high-risk pancreatic GIST, according to Fletcher (Fletcher et al., 2002).

Case 2. A 7x4x3 cm cystic mass, replacing almost entirely the head of the pancreas and compressing the duodenum wall, was observed (Fig. 2A,B). The lesion was well circumscribed with a brown greyish cut surface displaying haemorrhagic areas. The cystic cavity was full of necrotic debris. One peripancreatic lymph node was also identified, measuring 0.8 cm in its greatest dimension. Histologically, the tumour consisted of spindle cells with acidophilic cytoplasm and plump nuclei (Fig. 2C). The central part of the tumour was hypocellular showing necrosis, haemorrhage and mixoid changes of the stroma in which skenoid fibres were observed. Three mitoses on 50 HPF were found. The pancreatic parenchyma, the surgical resection margins and the peripancreatic lymph node were not infiltrated by neoplastic cells, whereas the tumour invaded the
muscularis propria of the duodenal wall. Immunohistochemically, neoplastic cells showed diffuse positivity to vimentin, CD117 (Fig. 2D), DOG-1 (Fig. 2E) and SMA and were only focally positive to CD34. Desmin and S-100 were negative. Ki-67 was about 1%. On molecular genetic examination, a deletion of 4 base pairs in exon 11 of \( KIT \) was found (Fig. 2F). The tumour was reported as intermediate-risk pancreatic GIST (Fletcher et al., 2002).

Case 3. The resected specimen showed a yellowish mass measuring 7×5.5×3.5 cm, partially (5%) solid located in the pancreatic body (Fig. 3A-B). Light microscopy showed the solid component to be composed of spindle-shaped cells in a fascicular arrangement intermingled with epithelioid cells (Fig. 3C). The cystic component displayed massive necrosis and diffuse haemorrhage. The neoplasms extensively infiltrated pancreatic parenchyma and duodenal wall but not the surgical resection margins. Neoplastic cells showed centrally located pleomorphic nuclei with large nucleoli and a mild-to-moderate rim of eosinophilic cytoplasm. The mitotic count was 15 mitoses on 50 HPF. Immunohistochemical co-expression of vimentin, CD117 (Fig. 3D), DOG-1 (Fig. 3E), CD34 and SMA was detected (Fig. 3C-D). Ki-67 was about 40%. Sequence analysis revealed an internal tandem repeat of codon 502 and 503 in exon 9 of \( KIT \) gene (Fig. 3F). A diagnosis of high risk pancreatic GIST was made (Fletcher et al., 2002).

Discussion

Pancreatic gastrointestinal stromal tumor is rare; so far, only 13 cases have been described in the literature (Neto et al., 2004; Yamaura et al., 2004; Krksa et al., 2005; Daum et al., 2005; Showalter et al., 2008; Yan et al., 2008; Harindhanavudhi et al., 2009; Trabelsi et al., 2009; Padhi et al., 2010; Saif et al., 2010; Rao et al., 2011; Vij et al., 2011; Cecka et al., 2011). The median age of the patients was 54.9 years (range: 31-72), with a female predominance (63%). The average diameter of the lesions was 15.8 cm. Only one of them was cystic (Harindhanavudhi et al., 2009). In 23% of cases, the diagnosis was incidental. Mutational analysis of \( KIT \) and \( PDGFR-\alpha \) genes was performed only twice (Daum et al., 2005; Saif et al., 2010). The treatment was surgery in 53.8% of cases, and surgery plus imatinib mesylate in 38% of cases. Three patients developed liver metastasis during the follow-up. Clinico-pathological and therapy data of all the 13 cases are listed in table 1.

In this paper we describe 3 cases of pancreatic GIST clinically and radiologically mimicking a cystic neoplasm of the pancreas. For this reason, a Whipple pancreaticoduodenectomy was performed (Steinberg et al., 2009).

In the differential diagnosis, pancreatic cystic lesions were excluded on the basis of morphology and immunohistochemistry (i.e. absence of epithelial cells lining the cyst and CD117 negativity) (Rosai, 2003). Retroperitoneal mesenchymal lesions were also considered. The intra-abdominal fibromatosis presents CD117 positivity in 75% of cases but it is characterized by a spatially homogeneous proliferation of wavy spindle cells without atypia, associated with collagen deposition (Rosai, 2003). The peritoneal solitary fibrous tumour shares CD34 positivity but lacks CD117 expression; the smooth muscle tumors, the GISTs, schwannomas and the undifferentiated sarcomas show some of the histological features of EGISTs but lack CD117 expression. (Yantiss et al., 2000; Graadt van Roggen et al., 2001).

To date, the origin of pancreatic GISTs remains controversial considering that the presence of Cajal cells has not yet been documented in the pancreas (Wang et al., 2011). It has been hypothesized that GISTs may result from the extensive extramural growth of mural GISTs, resulting in partial or complete loss of contact with the muscularis propria (Wang et al., 2011). Others suggested that the interstitial cells of Cajal may not be the actual cells of origin, but that GISTs could arise from a common precursor of Cajal and smooth muscle cells, explaining their growth within and outside the gastrointestinal tract (Wang et al., 2011).

To date, few data on the prediction of malignant potential of EGIST are available. According to Fletcher et al. (Fletcher et al., 2002) the main prognostic factors are tumor size and mitotic rate, although a low mitotic index and a small size do not guarantee a benign clinical course. Reith et al. (2000) analyzed 48 cases of EGISTs in order to determine their similarity to tumors arising from the gastrointestinal tract and reported that their malignancy was higher and similar to that of GISTs arising in the more distal part of the GI tract. Miettinen (Miettinen et al., 1999; Lasota et al., 2000) agreed with Reith et al. and proposed distinct guidelines for gastric GIST and for intestinal and extra-intestinal stromal tumours.

Approximately 75-80% of GISTs have mutations of the \( KIT \) gene (67% in exon 11, 10% in exon 9, 1% in exon 13 and 1% in exon 17). Mutations of \( KIT \) lead to the constitutional activation of tyrosine kinase activity, which is responsible for cellular proliferation and resistance to apoptosis. Eight per cent of GISTs showed \( PDGFR-\alpha \) gene mutations (exon 12, 14, 18) and 12-14% were wild-type, i.e. they do not have mutations either in \( KIT \) or in \( PDGFR-\alpha \) gene (Moskaluk et al., 1999; Morey et al., 2002; Bateman et al., 2008). Several studies reported a correlation between molecular alterations and biological behavior, prognosis and response to treatment. Wild-type GISTs have the worst prognosis, being resistant to imatinib treatment (Gharibo et al., 2008). \( KIT \) mutations in exon 11 are associated to better prognosis, usually found in GISTs with low risk features. As far as exon 9 mutations are concerned, exon 9 mutant GISTs are more aggressive than exon 11 mutants (Grabellus et al., 2010). Thus, among patients with advanced-stage GIST, those with exon 9 mutations show imatinib response, progression-free and overall survival.
intermediate between GIST with exon 11 mutation and wild-type GIST (Shimomura et al., 2010). Moreover, exon 9 mutations have been described only in gastrointestinal GISTs. In our cases, two unusual mutations of KIT gene were observed, both affecting exon 9. One of them [exon 9 single nucleotide substitution c.1427G>T (p.Ser476Ile)] has been previously described only in a 44-year-old male with a GIST of the stomach (Grabellus et al., 2010). Patient 1 reported in the present work and showing the same mutation, had a progression-free interval of 8 months which is shorter than that (14 months) of patients with the usual KIT exon 9 mutation under imatinib standard therapy. Owing to the absence in the literature of other pancreatic GISTs showing this particular mutation, the biological significance of exon 9 single nucleotide substitution remains unclear. The internal tandem repeat of codon 502 and 503 in exon 9 of the KIT gene, shown in patient 3, had been previously described only in a child with small intestine GIST (Shimomura et al., 2010). Shimomura hypothesized that this type of mutation may be associated to a better prognosis and response to imatinib mesylate. Unfortunately, limited follow-up (18 months) in our patient and the absence of other patients with pancreatic GISTs exhibiting the same mutation, does not allow us to confirm such a correlation.

Even though uncommon, pancreatic GISTs should be included in the differential diagnosis of both cystic and solid masses of the pancreas. Diagnosis should be achieved by the combination of radiology, histology, immunohistochemistry and molecular biology.

Acknowledgements. The authors would like to thank Professor Piero Tosi (University of Siena) for his expert review of the manuscript.

References


Steinberg W.M., Barkin J.S., Bradley E.L., DiMagno E.P., Layer P.,


Accepted June 11, 2014