


A Case of Newly Diagnosed Metastatic Pancreatic Cancer Presenting with Associated Immune Thrombocytopenic Purpura

Adarsh Varma, MD; Bret J. Spier, MD; Patrick R. Pfau, MD; Nasia Safdar, MD, MS

ABSTRACT
Metastatic pancreatic adenocarcinoma presenting with immune thrombocytopenic purpura is a very rare association. To date, only 1 case report found in the literature delineates such an association. We present a case of a patient with newly diagnosed, biopsy-proven metastatic pancreatic adenocarcinoma with new-onset immune thrombocytopenic purpura. The patient’s platelet count returned to normal limits after being treated with oral corticosteroid therapy. In conclusion, immune thrombocytopenic purpura can be associated with metastatic pancreatic adenocarcinoma and responds well to corticosteroid therapy.

INTRODUCTION
Pancreatic cancer is the fourth most common cause of adult cancer death in the United States.1 The high mortality rate from pancreatic cancer is a result of often-subtle clinical manifestations and a high incidence of metastatic disease at the time of diagnosis.

Pancreatic cancer manifesting with associated immune thrombocytopenic purpura has been previously reported in 1 case report in the literature.2 We present a case of a patient who presented with newly diagnosed metastatic pancreatic cancer with new-onset immune thrombocytopenic purpura.

CASE
A 60-year-old man who was previously healthy presented to the Emergency Department (ED) with 1 month of fatigue and a 20-pound unintentional weight loss. Over the past week, his friends had noticed yellowing of his skin, and he had noticed prolonged bleeding after shaving. The patient was on no medications prior to presentation. He denied any history of alcohol or tobacco use and reported no family history of malignancy. Review of systems was otherwise negative.

On physical examination, the patient was afebrile and hemodynamically stable. He was alert and oriented, pleasant and cooperative, but his skin was visibly jaundiced with associated scleral icterus, and his face had scattered cuts from the morning’s shave. Otherwise, there were no petechiae or ecchymoses appreciated. There was no hepatosplenomegaly, no fluid wave, and no stigmata of chronic liver disease. A neurologic examination revealed no focal deficits, and cardiac examination revealed a regular rate and rhythm, +S1S2, no murmurs, rubs, or gallops, and his lungs were clear to auscultation bilaterally.

Liver tests revealed a direct hyperbilirubinemia with a total bilirubin of 13.2 (0.3-1.9 mg/dL), a direct bilirubin of 11 (0-0.3 mg/dL), an alkaline phosphatase of 323 (39-117 U/L), elevated transaminases with an aspartate aminotransferase of 430 (5-40 U/L), and an alanine aminotransferase of 82 (7-56 U/L). A complete blood count revealed a severe thrombocytopenia with a platelet count <10,000 (150,000-450,000 platelets/microliter), a mild anemia with a hemoglobin of 11.9 (12.5-16 grams/dL), and a white blood count within normal limits. A chemistry panel revealed serum creatinine of 0.7 (0.7-1.4 mg/dL) and mild hyponatremia with a sodium of 133 (136-145 mEq/L).

A computerized tomography (CT) scan of the abdomen revealed a mass at the head of the pancreas, multiple liver lesions, trace ascites, no splenomegaly, and extensive lymphadenopathy.

To further work up the patient’s thrombocytopenia, a peripheral blood smear was obtained, and this revealed occasional elliptocytes. As the patient was...