0008-3194/95/18–21/$2.00/©JCCA 1995

# Pancreatic cancer and chronic thoracic back pain: a case report

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*A male with persistent thoracic spine pain and clinical symptoms suggesting a more grave condition than mechanical back pain is presented. The patient had previously been attended to by a medical doctor and a chiropractor. The symptom picture and the ineffectiveness of previously administered chiropractic care suggests a medical referral with further investigation. The importance of history taking is emphasized. An accurate diagnosis and administration of the appropriate treatment is paramount because the prognosis of detected pancreatic cancer is poor.*
(JCCA 1995; 39(1):18–21)

KEY WORDS: thoracic spine pain, pancreatic cancer, history taking, chiropractic, manipulation

*On présente un homme souffrant de douleur persistante au niveau de la colonne thoracique avec des symptômes cliniques qui semblent indiquer une affection plus grave qu'une douleur lombaire de nature mécanique. Le patient a été déjà examiné par un médecin et un chiropraticien. Les symptômes et l'inefficacité des soins chiropratiques préalablement administrés conduisent à recommander le patient à un autre spécialiste et à effectuer un examen plus approfondi. On insiste sur l'importance de l'interrogatoire médical. Il est fondamental d'établir un diagnostic précis et d'administrer un traitement adéquat car le pronostic du cancer du pancréas qui a été détecté est sombre.*
(JCCA 1995; 39(1):18–21)

MOTS-CLES : douleur de la colonne thoracique, cancer du pancréas, interrogatoire médical, chiropraxie, manipulation.

## Introduction

Pancreatic cancer affects one in ten thousand persons in the United States.[1] The symptom of thoracic spine pain and its association to pancreatic disease has been described previously.[2] Conditions affecting the thoracic spine may be a direct irritation, such as arthritis, ankylosing spondylitis, infective and neoplastic disease, trauma and postural stress.[3] Canadian chiropractors uncommonly see patients with gastrointestinal complaints as either a presenting or concurrent condition.[4] Nevertheless, patients attending a chiropractor for discomfort that is unremitting, and/or progressive, should consider the possibility of a grave situation existing.

Patients presenting to a chiropractor for long term palliative care, may have concomitant pathology.[1] The clinician should rely on a careful case history, with common sense illuminating the possibility of and increasing the index of suspicion of pancreatic cancer.[5]

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The case presented illustrates a patient specifically reporting symptom patterns typical of pancreatic cancer. In this case, an early diagnosis was not made by either the chiropractor or the family physician. The common presenting signs and symptoms are described. The need to regularly assess the symptoms reported by a patient are discussed.

Illustrations of the patient's CT scan along with a CT scan of a normal pancreas are provided.

## Case Report

A 64-year-old chiropractor presented with middle to low thoracic spine pain. The patient had a 30-year history of similar pain, but in the last year the intensity of the pain had increased and the relief from chiropractic spinal adjustments had diminished. The patient was diagnosed with adult onset diabetes six months previous and had instituted a diet to control it. The case history revealed that the patient's mother had succumbed to the complications of diabetes 40 years previous.

Within the last three months, the pain became nocturnal in the lower thoracic spine area and the weight loss continued beyond what the patient expected with the effort of his diet. Upon questioning, the patient related that the fatigue he had experienced had induced a complete collapse while on vacation

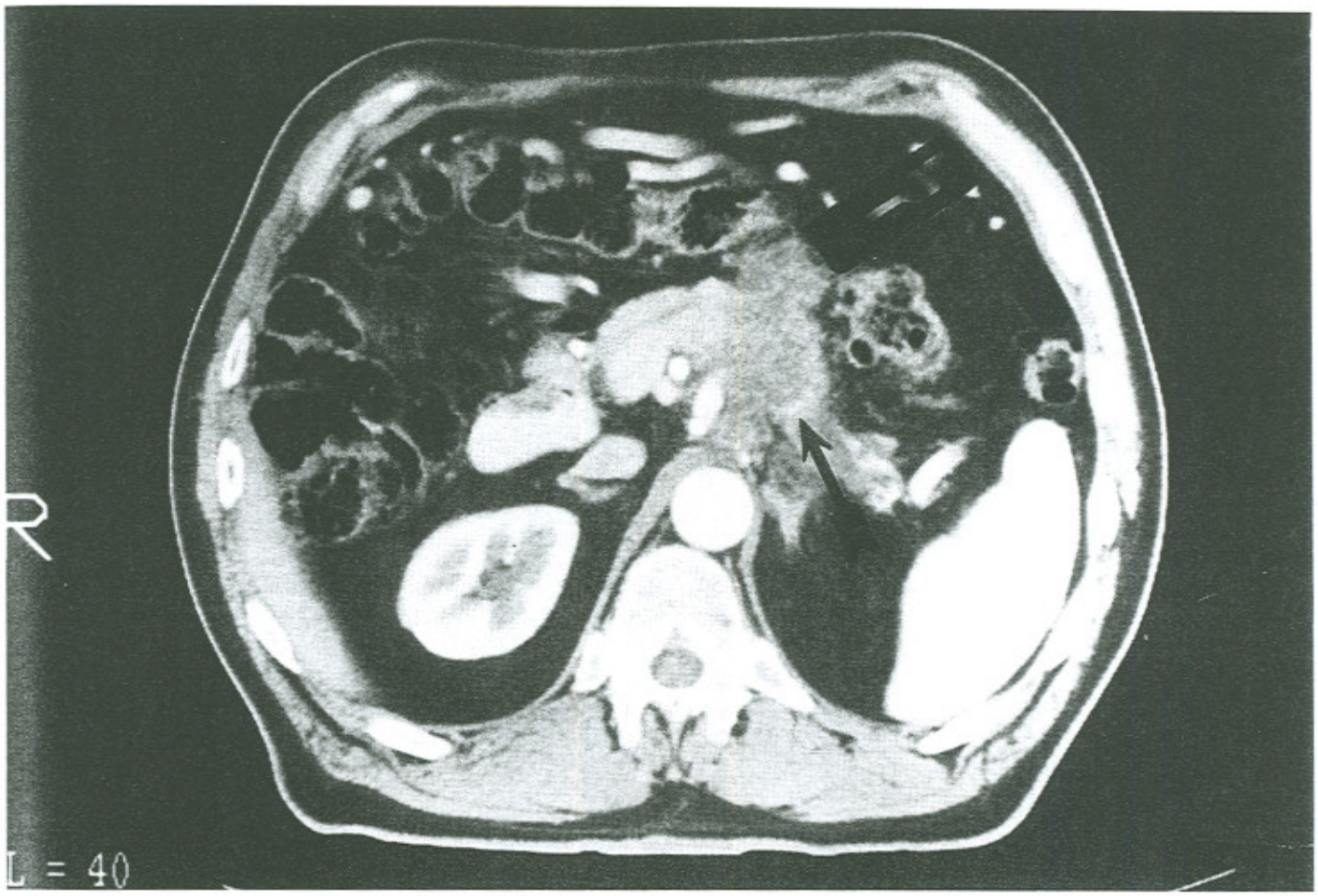


**Figure 1** The enlarged body and tail of the pancreas illustrated with arrows.

the previous month. The patient attributed this lapse in consciousness to not eating at his regularly scheduled time. The symptom of fatigue had started to worry the patient and the concern for another opinion was expressed.

The examination showed a remarkable range of motion to the dorsal-lumbar spine. The eight to the twelfth thoracic vertebra were tender to palpation, but the patient mentioned this tenderness was no more than in previous years. Some paraspinal muscle spasm was palpable and the sacroiliac joints were fixed upon motion palpation testing. The neurological examination, including abdominal reflexes, were normal. The abdomen was distended and rigid. A consultation was arranged with a surgeon three days later. The surgeon's initial concern was the weight loss and the chronic fatigue. Arrangements were made to have a CT scan to assess the site of greatest discomfort.

The CT scan revealed an enlarged body and tail of the pancreas (figure 1). The surgeon made a diagnosis of endocrine pancreatic cancer. Needle aspiration was not carried out due to the progression of the neoplasm. It was felt that resection of the pancreas would provide neither hope for recovery nor a potential palliative effect.

The patient continued to maintain as normal a lifestyle as possible with medication providing pain relief. Two months after diagnosis, the patient succumbed to a severe painful abdominal attack, was hospitalized, and within 24 hours the patient died.

## Discussion

The most common symptoms of pancreatic cancer are epigastric and/or periumbilical pain (especially when recumbent), weight loss, jaundice, depression, peripheral manifestations, steatorrhea and diabetes.[1]

Pain in pancreatic cancer is often deep-seated in nature, situated to the right or left of the midline. The pain is often

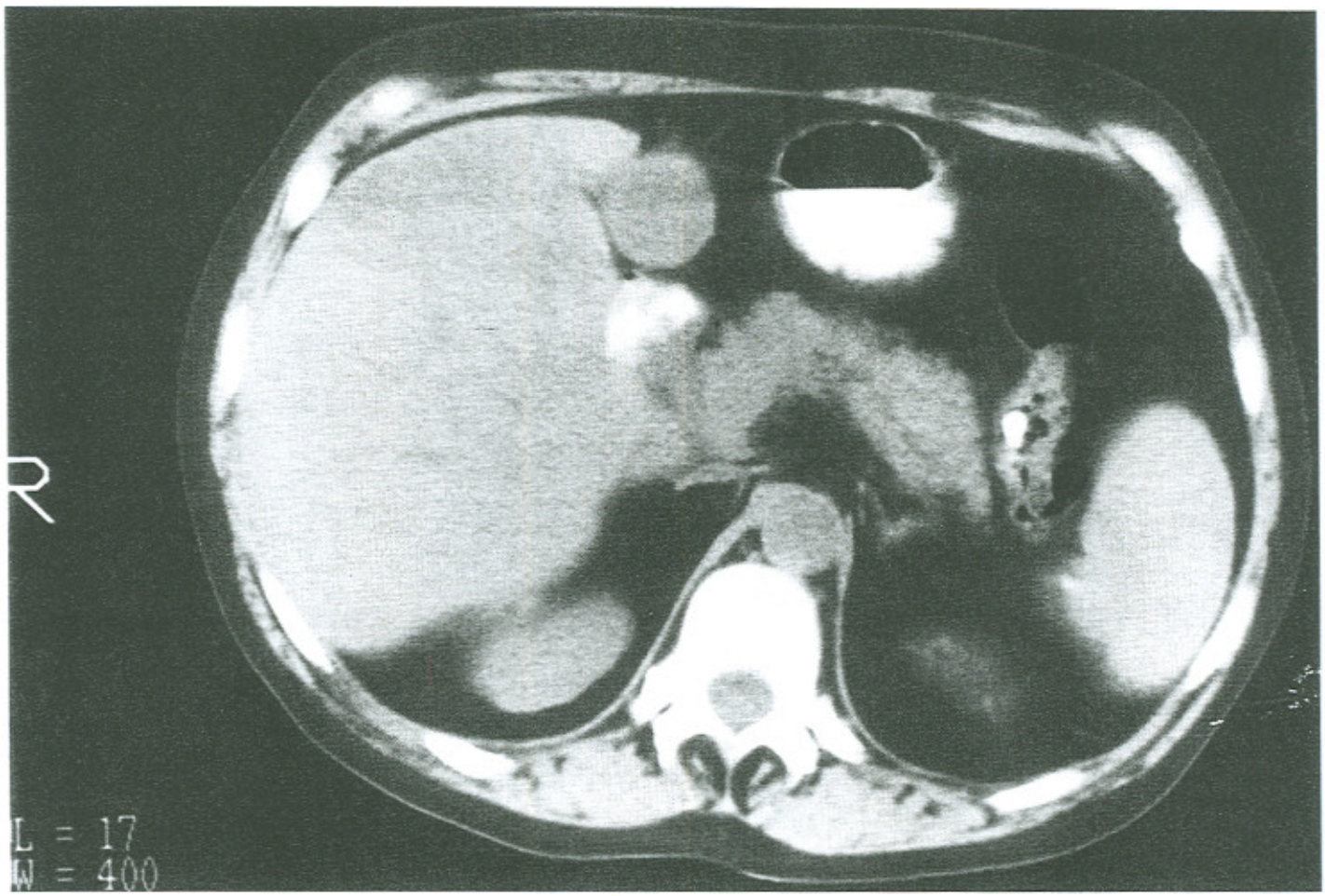


**Figure 2** The normal contour of the pancreas.

progressive, with the patient initially finding relief with standing and bending forward. It is important not to confuse this pain abatement with a biomechanical etiology as in the case of facet joint irritation which may be temporarily relieved with forward trunk flexion.[6] The referred pain symptoms associated with acute pancreatitis are pain to the tenth to twelfth thoracic vertebrae.[3] The pain of abdominal origin is characterized by its steady and progressive nature.

In the initial stages, the pain will not be accompanied by digestive changes. Only those pancreatic cancers with growth in the head, as opposed to the body and tail regions of the pancreas, will start with digestive tract dysfunction and possible jaundice. Weight loss from 6–15 Kg with or without a decrease in appetite, should alert the clinician to referral to an informed medical specialist. Jaundice with pancreatic cancer occurs due to the growth blocking the common bile duct, but the body and the tail are more frequently involved than the head. Fatty stools are usually a late manifestation of pancreatic insufficiency.[7]

Many patients suffering from pancreatic cancer are getting treatment for psychoneurosis or neurotic depression. Spiro makes the suggestion that the patient at middle age with an undiagnosed abdominal pain, may be suffering from depression or anxiety that clouds the true symptom picture.[1] Venous thrombi and pulmonary emboli may be the early signs of an enigmatic pancreatic tumour growth.

The previous diagnosis of diabetes is a very common precursor to pancreatic cancer. Middle aged diabetics with new abdominal pain should always be suspected of pancreatic tumour growth.[1] The presence of a rigid or distended abdomen as a clinical finding may confirm the non-mechanical origin of pain. This raises the clinical issue of whether all patients who complain of thoracic or lumbar spinal pain should undergo a screening abdominal examination at the initial doctor-patient interaction.

The above symptom picture provides the clinician with data to consider a diagnosis of pancreatic cancer until proven otherwise. A palpable mass is usually the first physical examination finding which is usually an indication of a grave prognosis. The suspicion of pancreatic cancer should be followed by a CT scan. Should a normal CT scan be reported (figure 2), further testing may be conducted with needle biopsy, liver function tests, ultrasonography, barium studies and endoscopic examination. Most of the follow-up testing leads to a controversial issue of whether to resect the pathologic pancreatic tissue or to allow the patient to have the neoplasm run its course. Malignancies are conditions for which high-velocity thrust procedures to the areas of pathology are contraindicated.[8] Unfortunately pancreatic cancer is usually fatal within 6 months of detection.[1]

## Summary

This case illustrates the need for all clinicians to listen and observe the changing symptom picture of the patient and to be cognisant of the ineffectiveness of therapy that previously provided relief. The chiropractor treating in this case may have become complacent due to the professional association with his "comrade". The medical doctor in this case may well have assumed the weight loss to be expected with the initiation of the diabetic diet. Both of these practioners missed the hints in the history taking that would have led to the suspicion of a more ominous diagnosis.

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