Incidental retroperitoneal paraganglioma, imaging workup and CT-guided biopsy: A case report

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Abstract
Extra-adrenal paraganglioma of the retroperitoneum is a very rare neoplasm arising from cells of the primitive neural crest. We report a case of an 80-years-old woman, who has been transferred to our neurology department with unsteady gait and ataxia, no abdominal pain, accidentally – as part of polyneuropathy screening – a retroperitoneal tumor situated at the aortic bifurcation was found in an ultrasound examination. At first our suggested diagnosis was a GIST, so we performed a CT guided core biopsy, the histology result was a paraganglioma, so we did a blood test, which showed elevated noradrenaline in plasma and normetanephrine in urinalysis. The patient showed no metastasis in PET CT Scan and was successfully treated by complete surgical removal of the tumor.

Introduction
Retroperitoneal neoplasms are rare tumors, easily misdiagnosed and present several therapeutic challenges because of their rarity and relatively late presentation. Paragangliomas are tumors that arise from extra-adrenal medullary neural crest derivatives. They are usually located in the head and neck but can be found in various body sites, including the chest cavity, abdomen, pelvis and bladder.

They can occur at any age, most commonly in young adults. The patient show a median age of 37 – 43 years, the distribution between male and female patients is balanced (1:1) [1,2].

We report the case of an 80-years-old asymptomatic woman, with accidental diagnosis of a retroperitoneal paraganglioma.

Case report
We present a case of an 80-year old female patient, who was transferred to our neurology department with unsteady gait and ataxia. Patient’s history was largely unremarkable, mild arterial hypertonus was well treated with an ACE-Inhibitor. There were no hypertensive crises in her anamnesis.

As part of a polyneuropathy screening an ultrasound examination of the abdomen and pelvis showed an unclear, heterogeneous lesion in the left abdominal cavity without organ reference.

Subsequent examination with CT showed an inhomogeneous, encapsulated, partially contrast enhancing tumor, with 8 x 5 cm diameter. It was located retroperitoneal with close connection to the abdominal aorta and the inferior mesenteric artery. Especially in the arterial phase it showed a heterogeneous contrast-enhancement (Figure 1). Our suspected diagnosis at this time was a gastrointestinal stromal tumor (GIST). Also a PET-CT was performed. It showed a low FDG-uptake with an SUV of 5,4. Furthermore, no metastatic lesions could be detected.

In consultation with colleagues from our neurology, surgery and internal medicine department, we decided to perform a CT-guided biopsy of the suspicious tumor (Figure 2).

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Paragangliomas and pheochromocytomas can occur hereditary with a strong association to other genetic diseases like neurofibromatosis type 1, multiple endocrine neoplasia (MEN 2 a/b), von Hippel Lindau (vHL) and familial PGL syndrome [7].

In 50 % the patients present with symptoms, such as palpitations, headache, sweating and hypertension caused by catecholamine secretin, the other half are nonfunctional paragangliomas. Retroperitoneal paragangliomas sometimes lead to nausea, vomiting, constipation and abdominal pain, sometimes the tumor causes ileus [8].

Often the diagnosis of non-functional paragangliomas is, because of absent clinical symptoms, delayed, so they pose a significant diagnostic challenge [2].

10 to 15 % of paragangliomas can be malignant based on histologic analysis [9], but the only reliable criterion remains the presence of distant metastases. Metastasis of paraganglioma occurs usually in the lungs, lymph nodes, liver, bones or the spleen. Most paragangliomas have an intact capsule with abundant blood vessels both on its surface and inside. Therefore, most paragangliomas can be removed without any complications [10].

A preoperative medication, e.g. Phenoxybenzamine – a very expensive option - is recommend in order to perform a safe resection. Alternative, α1-selective blockers (prazosin, doxazosin, terazosin), calcium channel blockers, angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers, β-adrenergic blockers, and α2-agonists have been successfully used in preoperative management. Intraoperative vasodilators and esmolol are also recommended. [7].

Laparoscopic surgery is a safe curative method in non-metastatic situation, with a quick postoperative recovery and no negative influence on local recurrence. Another therapeutic option for malignant paragangliomas is radionuclide therapy with radioactive iodine coupled with MIBG [11] .

For patients with metastatic paraganglioma resection is not a curative therapeutic option, but patients may benefit from an operation because of decreasing levels of catecholamine surge. Furthermore, resection prevents abdominal and retroperitoneal complications of the tumor (i.e. acute abdomen by ruptured retroperitoneal paraganglioma [5]) and increases the efficacy of adjuvant systemic therapies. Other therapeutic options in cases of metastatic tumors are radiation therapy and ablative procedures [12].

Conclusion

Our case intends the need to consider paraganglioma of the retroperitoneum in the differential diagnosis of retroperitoneal tumours. Our first suspect was a GIST and so we carried out a CT guided core biopsy. Afterwards the blood and urine examination showed elevated noradrenaline and normetanephrine. PET CT scanning for metastasis was negative. Finally, our patient was successfully treated by complete surgical removal of the tumor.

Long-term follow-up is mandatory in those patients, because of the recurrence risk. Monitoring of hypertension and plasma or urine metanephrine levels are recommended (i.e. 10 days after operation and once a year for life). If the patient is asymptomatic, the screening can be based on a discussion with the patient and an informed decision could be made [3].
Disclosure

All co-authors do not report conflicts of interest.

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