

with no overt vascular risk factors should be considered for cancer screening [1,4,5,6]. For this patient CA19-9 was extremely high and a large silent necrotic mass in pancreatic tail were seen on abdominal CT. The combination of radiology with a best serum tumor marker for pancreaticobiliary cancer CA19-9, significantly increases the diagnosis sensitivity to 97.2% and the specificity to 88.7% [7]. The presented patient has necrotic stage IV adenocarcinoma of pancreatic tail with hepatic and splenic metastases and multiple acute cerebral ischemic stroke as the first symptom, which is very rare. Adenocarcinoma of pancreatic tail often grows silently and the most common clinical manifestation is glucose tolerance disorder [11]. The underlying pathophysiological mechanisms for the presence of the cerebrovascular diseases, due to the pancreatic cancer itself, are unclear [9,10,15,16]. For this patient, except the elevated serum pancreatic carcinoma antigen and mild hepatic pathology, the coagulation factors and all of the rest blood tests were within normal limits. Ultrasonographic duplex study, trans-thoracic echocardiography and chest findings were normal. We speculate that in our case the cause of the multiple cerebral infarctions may have been due to migratory arterial tumor emboli from necrotic pancreatic cancer.

IV. Conclusion

We conclude that patients with multiple, repeated cerebral infarction, with minimal risk factors for stroke, must be further investigated for an underlying malignancy, possibly of pancreatic origin.

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