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Cancer. 2004 100 (12): 2664-2670. 10.1002 / cnr.20290.articleÂ, PubMedÂ, Google ScholarÂ, Page 2â, Values HR Value P Eta Mediana (YR) 59 (38 to 72) 1.04 0.16 Sex Â, Â, Â, M 65% 0.89 0.85 f 35% f, Â, ECOG PS (%) Â, 1.04 0.92 0 30 Â, Â, 1 60 Â, Â, 2 10 Â, Â, 3 and 4 0 Â, Â, n * of sites Â, 0.80 0.74 1 75% Â, Â, 2 25% Â, Â, > 2 0% Â, Â, initial sites Â, 0.99 0.99 liver 15%, Â, lungs by 10% Â, Â, peritoneal by 20% f, Â, local 25%, Â, nodal 0% Â, Â, bone 5% combinations Â, Â, Â, 25% median age was determined at the time of diagnosis of metastatic disease or recurrence documentation . M = male; F = female; ECOG PS Site performance according to the Eastern Cooperative Oncology Group: NO SITES = Number of metastatic sites at the time of diagnosis of metastatic or recurrence illness; Initial sites = percentage of metastatic initial sites / applicants according to the organ involved. HR = Hazard Ratio for global survival after univariate analysis. Value of P = level of significance. Final diagnosis: Â, Â, Â, Â, adenocarcinoma pancreas with kit adenocarcinoma syndrome of the pancreas, moderately to the scarcely differentiated ductal type, with metastasis a: duodenum stomach lymph nodes transverse colon peritoneo common bile duct, with stenosis, the positioning of status after Trousseau syndrome stent, with: Pulmonary thromboembolie, recent left and right pulmonary hemorrhage and the organization of pancreatic carcinomes infarsters arise in the portion of the escocrine of the gland. Virtually all these tumors arise in the ductal epithelium. Pancreatic adenocarcinoma often grows in silence, so that from the moment it is diagnosed it will rarely curable. The median time of survival after the diagnosis, regardless of therapy, is only a few months. Pancreas cancer represents 5% of all deaths for cancer in the United States. These tumors occur more often in sixth, seventh, eighth and decades of life, even if about 10% of patients are much younger. The incidence is increasing, but the causes are elusive. Smoking, diet and carcinogenic chemical substances have been implicated. There is a positive correlation between the mortality for pancreas cancer and the per capita consumption of fats and meat. The lesions can arise anywhere in the pancreas: 60% is in the head, 15-20% in the body, and 5% in the pancreas queue. In 20% of cases, the tumor is widespread or widespread so widely that the location of the Site of origin is impossible. Pancreas head tumors affect vater, common bile duct, and duodenum and therefore cause bile obstructive symptoms that can occur relatively early in the course. Body tumors and the tail tend to grow silently and metastatize before the diagnosis. These lesions are probably present for months or years before producing symptoms due to their expansive growth. The main symptoms are weight loss, abdominal pain, backache, anorexia, nausea, vomiting and general illness, and weakness. Iflet is present in about 90% of patients with head carcinomas and 10 to 40% of those with body cancer or tail. The symptomatic pancreatic cancer course is typically short and progressive. Despite the tendency of the lesions of the pancreas head to hinder the biliary system on a relatively early date, less than 15% of pancreatic tumors overall are resectable at the time of diagnosis. A Year is less than 20%, and the 5-year survival is only 3%. Coarsely, pancreatic head carcinomas can be quite small or up to 10 cm in diameter. The gray-white, gray-white schirrous. The tumor infiltrates and replaces the lobular architecture of a normal pancreas. These lesions have badly defined, obviously infiltrative magic. The larger tumors usually extend beyond the pancreas to invade the duodenum and the duct of the common bile; The biliary obstruction can occur by compression or final growth of cancer in the biliary space. The extension to peripancreatic and porterhepatic nodes, with liver metastases, is not rare. The histological aspect of pancreatic carcinoma is generally that of a poorly differentiated adenocarcinoma that forms abortive tubular structures or cellular clusters and exhibiting a model of aggressive and profoundly infiltrative growth. The malignant glands are atypical, irregular, small and bizarre and are usually flanked by anaplastic cuboidal epithelial cells to columns. Well, moderately differentiated tumors are the exception. There can be areas of ductal dysplasia and intraductive cancer growth. The dense stromale fibrosis accompanies the invasion of the tumor, and there is often perineal invasion inside and beyond the organ. This Perineural invasion often explains intractable pain. Migratory thrombophlebitis, known as the Trousseau syndrome, which occurs in about 10% of patients with pancreatic adenocarcinoma, is attributed to the processing of platelet factors and the procoagulants of the tumor or its necrotic products. Trumpets both venous and arterial may occur. Venous trails can embilize the lungs. A large "saddle" pulmonary embolus can lead to a sudden dissupteas and a disappearance of the patient. Smaller emboli, as in this case, can produce pulmonary heart attacks with a bit of dissipnea and chest pain. References: Wenger Fa, Peter F, Zienen J, Steiert A, Jacobi CA, Muller JM. Prognosis factors in pancreas's head carcinoma. Digging off. 2000; 17: 29-35. Paulino AC, Latona C. PANCREAS non-rescable adenocarcinoma: Troubleshooting models and treatment results. Cancer invest. 2000; 18: 309-13. NASCITZ JE, YESHURUN Â €

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