Pancreatic cystic neoplasm presenting as a large gastric ulcer

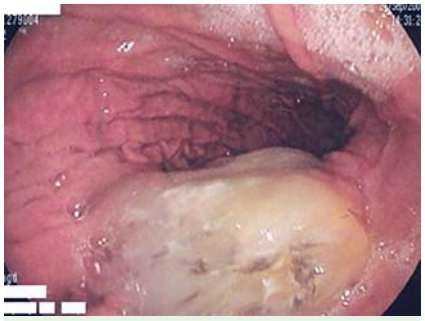

Fig. 1 Esophagogastroduodenoscopy showing a large, mucus-secreting gastric ulcer.

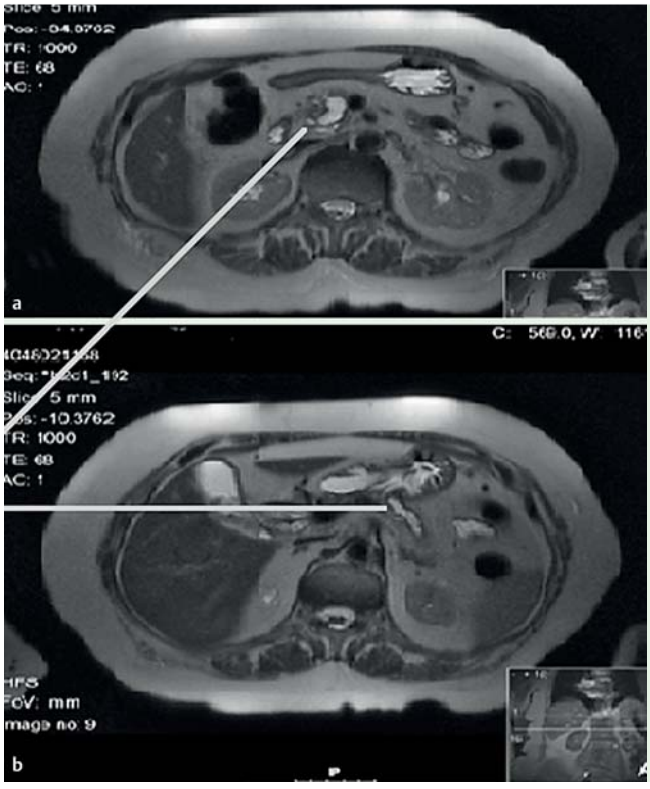

Fig. 2 Magnetic resonance cholangiopancreatography (MRCP) showing: **a** the dilated pancreatic duct that had formed a fistula; **b** the stomach with the other end of the fistula.

An 85-year-old woman was admitted with painless obstructive jaundice that had developed over the previous few weeks. Ultrasound examination showed intrahepatic and extrahepatic duct dilatation; the common bile duct (CBD) measured 2.5 cm, and there was a suggestion of pancreatic duct dilatation. A few gallstones were identified in an otherwise normal-looking gallbladder, but no obstructing CBD stones were seen. The dilated biliary system was confirmed by endoscopic retrograde cholangiopancreatography (ERCP); no stones were identified in the CBD, but a copious amount of mucus was cleared from the duct. A large gastric ulcer was also noted at ERCP, which was confirmed on formal gastroduodenoscopy and was also seen to be secreting thick mucus into the stomach (**Fig. 1**).

A computed tomography (CT) scan showed a cystic pancreatic mass, and on magnetic resonance cholangiopancreatography (MRCP) the dilated pancreatic duct was seen to form a connection to the stomach (**Fig. 2**).

Gastric ulcer biopsies showed fragments of a severely dysplastic villous tumour, but biliary brushings were inconclusive. An endoscopic ultrasound (EUS) with fine needle aspiration was performed, which confirmed the eventual diagnosis of a mucinous cystadenoma of the pancreas with a fistulating gastric metastasis. There were extensive discussions with the patient and her daughter about further treatment options, but clinically she had become very frail, experiencing further bouts of cholangitis that required insertion of a metal stent, so the multidisciplinary decision was for palliative management.

Differentiation of pancreatic cysts between benign and malignant causes can be difficult, requiring a combination of clinical, radiological, and histological approaches [1]. The fistula seen in this case between the mucinous cystadenoma and the stomach wall represents a rare finding, not being a previously reported feature of pancreatic cystic neoplasms.

Endoscopy_UCTN_Code_CCL_1AB_2AD_3AC

Competing interests: None

S. Mathew, S. Gupta, M. Mendall, D. Sarma
Department of Gastroenterology, Croydon University Hospital, UK

References

1 *Khalid A, Brugga W.* ACG Practice guidelines for the diagnosis and management of neoplastic pancreatic cysts. Am J Gastroenterol 2007; 102: 2339 – 2349

Bibliography

DOI 10.1055/s-0030-1256644
Endoscopy 2011; 43: E363
© Georg Thieme Verlag KG Stuttgart · New York ·
ISSN 0013-726X

Corresponding author

S. Mathew, MD
Department of Gastroenterology
Croydon University Hospital
Croydon
CR7 7YE
UK
Fax: +020-8401-3495
sanjumathew@doctors.org.uk

This document was downloaded for personal use only. Unauthorized distribution is strictly prohibited.