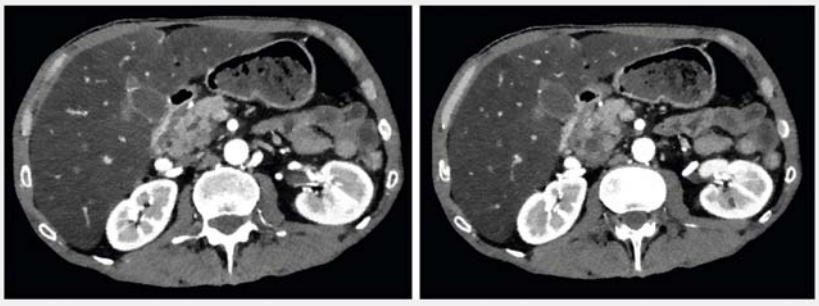
Endoscopic findings of paraduodenal or groove pancreatitis

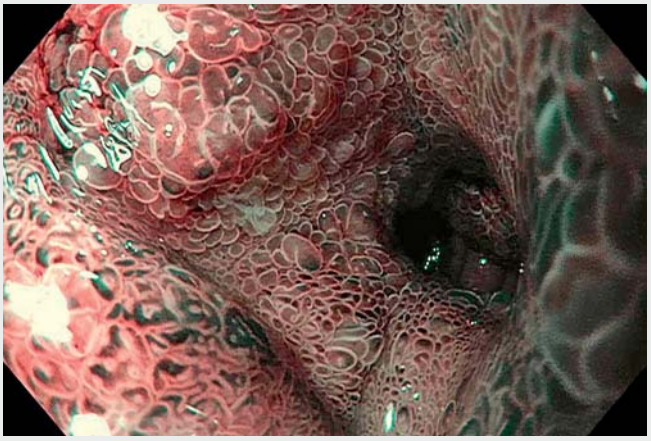
Paraduodenal pancreatitis is an uncommon type of focal chronic pancreatitis characterized by scarring of the pancreaticoduodenal space. The possible pathogenesis includes disconnection or impairment of communication between the ducts of Santorini and Wirsung [1]. The clinical presentation of paraduodenal pancreatitis can be similar to that of pancreatic head carcinoma, so its diagnosis and treatment is usually a challenge. Other previous entities with similar clinicopathological features, such as duodenal cystic dystrophy, duodenal wall cyst, or groove pancreatitis, should no longer be used [2, 3].

The clinical presentation of paraduodenal pancreatitis is secondary to duodenal stenosis and comprises recurrent episodes of abdominal pain, nausea, and vomiting. Conservative medical treatment is the standard of care, but surgery accounts for 12.8 %–19.5 % of pancreaticoduodenectomies performed for chronic pancreatitis [3]. This occurs because of misdiagnosis as pancreatic cancer and failure of medical treatment. Herein, we present a case of paraduodenal pancreatitis with its unique and illustrative endoscopic findings.

A 49-year-old man with a past history of chronic alcohol consumption presented with epigastric abdominal pain, vomiting, reduced oral intake, and diarrhea. He had a history of admissions for acute alcoholic hepatitis and Wernicke–Korsakov encephalopathy. His physical examination revealed abdominal tenderness, while no abdominal mass was detected. Laboratory tests revealed macrocytic anemia, hyperamylasemia (> 3 × normal), and cholestasis, along with low pancreatic fecal elastase levels. A computed tomography (CT) scan revealed cystic thickening of the duodenal wall, with duodenal stenosis (▶ **Fig. 1**).



▶ **Fig. 1** Computed tomography (CT) scan showing cystic thickening of the duodenal wall, with duodenal stenosis, fibrous tissue within the pancreaticoduodenal groove, and swelling of the pancreatic head, with a 30-mm hypodense cystic lesion communicating with a slightly dilated pancreatic duct.



Video 1 Upper gastrointestinal endoscopy showing a congested, edematous, and erythematous mucosa in the second part of duodenum, around the major papilla.

Upper gastrointestinal endoscopy was performed to rule out portal hypertension; neither varices or portal hypertension gastropathy were found. However, a duodenal stricture, allowing passage of the scope, was observed. The duodenal mucosa was congested, edematous, and erythematous in the second part of duodenum, around the major papilla (▶ **Video 1**). Conservative management with fasting and parenteral nutrition for 4 days was successful. Pancreatic enzyme replacement therapy was initiated and the patient was discharged 7 days after the endoscopy.

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Competing interests

The authors declare that they have no conflict of interest.

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