

Occult pancreatic head cancer in the setting of gallstone and common bile duct stones complicated by acute pancreatitis

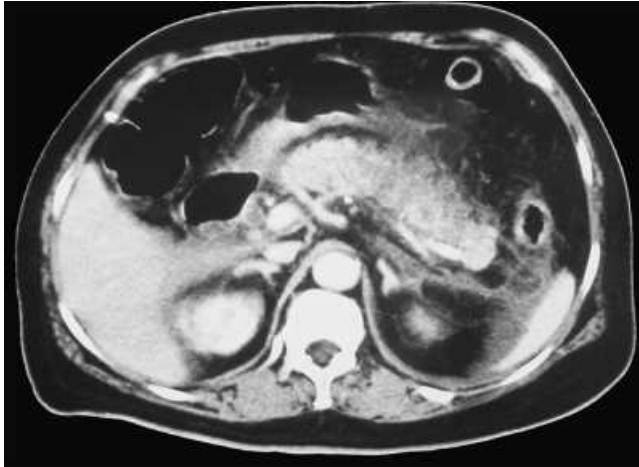


Fig. 1 Computed tomography scan obtained during the third day from symptom onset showed peripancreatic fluid collection, suggestive of acute pancreatitis.

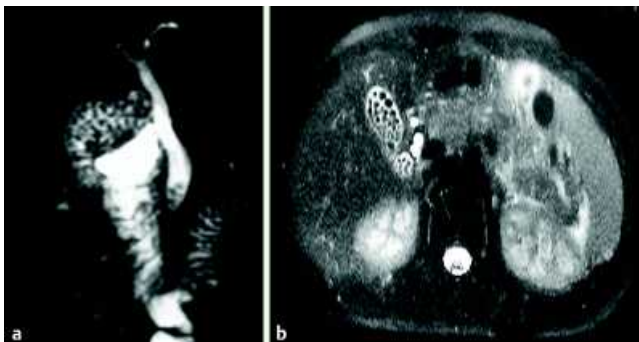


Fig. 2 Magnetic resonance imaging revealed the presence of both common bile duct stones (a) and gallstones (b).

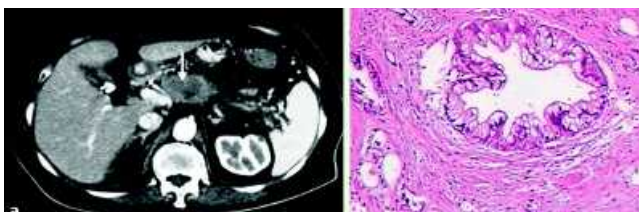


Fig. 4 (a) Computed tomography scan revealed a hypodense mass lesion (white arrow) in the pancreatic head. (b) Cytological evidence of pancreatic cancer.

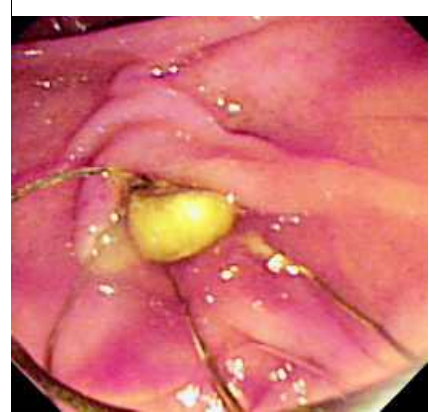


Fig. 3 Uneventful stone extraction by Dormia basket.

Acute pancreatitis usually results from alcohol abuse or biliary obstruction [1], however, it can also result from pancreatic cancer [2]. The association between acute pancreatitis and pancreatic cancer has been reported [3], and the majority of these cases were initially misinterpreted as idiopathic pancreatitis. This is the first report describing a case of pancreatic cancer in the setting of biliary stones complicated by recurrent acute pancreatitis.

A 79-year-old woman presented with intermittent upper abdominal pain for 10 months. She had experienced an episode of acute pancreatitis 10 months previously, and gallstones were detected by transabdominal ultrasound; but she declined

laparoscopic cholecystectomy. Seven months later, the abdominal pain recurred. Based on the symptoms, significantly elevated serum amylase, and computed tomography (CT) findings (Fig. 1), acute pancreatitis was diagnosed. Magnetic resonance imaging (MRI) revealed both common bile duct (CBD) stones (Fig. 2a) and gallstones (Fig. 2b). She underwent laparoscopic cholecystectomy uneventfully. She was later referred for CBD stone removal.

Her physical examination and laboratory findings were unremarkable. During endoscopic retrograde cholangiopancreatography, the papilla was examined and no obvious abnormality was found. Cholangiogram detected multiple filling

defects, suggesting CBD stones. These stones were extracted completely (Fig. 3).

However, the patient complained of recurrent severe epigastric pain afterwards. An abdominal plain radiograph did not suggest duodenal perforation, and serum amylase was unremarkable. We proceeded with a CT scan, and it showed a pancreatic head hypodense mass (Fig. 4a). Subsequent endoscopic ultrasound-guided fine-needle aspiration revealed pancreatic adenocarcinoma (Fig. 4b).

In the exudative phase of acute pancreatitis, the acute fluid collection and non-enhanced pancreatic parenchyma may obscure the appearance of pancreatic cancer; therefore, the initial mass could have been missed during initial CT due to the acute inflammatory changes. Therefore, when pancreatic cancer is suspected, CT scanning during the pancreatic parenchymal phase is quite important to detect the malignant lesions [4].

Endoscopy_UCTN_Code_CCL_1AZ_2AB
Endoscopy_UCTN_Code_CCL_1AZ_2AD

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Bibliography

DOI 10.1055/s-2008-1077439
Endoscopy 2008; 40: E207 – E208
© Georg Thieme Verlag KG Stuttgart · New York ·
ISSN 0013-726X

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