A 24-year-old man, who was an active smoker (20 cigarettes per day) since the age of 7 years and had a history of chronic alcohol abuse, was referred to our hospital because of recurrent mild-severe abdominal pain localized in the upper quadrants and sometimes radiating to the back. In 2012 he was hospitalized for an episode of alcoholic mild-acute pancreatitis. He then stopped drinking alcohol for 3 years, with clinical and nutritional benefits. In 2015 he began abusing alcohol again, and the abdominal pain recurred together, with progressive weight loss.

Because of the persistence of symptoms, biochemical blood tests were performed and showed a mild increase in gamma-glutamyl transferase (2× the upper limit of normal [ULN]), amylase/lipase (2.5/1.5×ULN), and carbohydrate antigen 19–9 (2×ULN). A computed tomography scan showed the presence of a hypodense area between the head of the pancreas and the duodenal wall, which contained some cysts associated with millimetric calcifications (Fig. 1). A magnetic resonance imaging (MRI) scan confirmed an isointense area containing small multiple cysts (Fig. 2). To better clarify the nature of these findings, we performed an endoscopic ultrasound (EUS), which showed an inhomogeneous area between the head of the pancreas, the duodenum, and the common bile duct, with multiple small anechoic lesions and millimetric calcifications (Fig. 3, Video 1). These findings, together with clinical and anamnestic data, are consistent with a diagnosis of the cystic variant of pure-type groove pancreatitis [1], a rare form of chronic pancreatitis also known as cystic dystrophy of the heterotopic pancreas, paraduodenal wall cyst, myoadenomatosis, or paraduodenal pancreatitis [2]. EUS is now considered an important tool, together with MRI, for a diagnosis of groove pancreatitis [3–5]. However, EUS morphologic features of groove pancreatitis have not been extensively reported to date.

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Competing interests

None

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