Intraductal papillary mucinous pancreatic neoplasms (IPMNs) are very common lesions. International guidelines recommend surveillance or more invasive management according to precise criteria [1]. A very rare complication of these lesions is the fistulization to an adjacent structure of the pancreas [2, 3].

We report the case of a 90-year-old man with jaundice in the context of metastatic prostatic adenocarcinoma. A cephalic cystic lesion of the pancreas was known and stable during his oncologic follow-up. An abdominal-pelvic computed tomography scan found major dilation of the common bile duct (measuring 27 mm) and of the main pancreatic duct (12 mm). A cephalic multiloculated cystic mass was also described, measuring 77 × 78 mm with irregular parietal nodular contrast, compatible with IPMNs (▶ Fig. 1, ▶ Fig. 2).

Endoscopic ultrasonography confirmed the diagnosis of IPMN with high-risk stigmata (main pancreatic duct > 10 mm and enhancing mural nodule > 5 mm). Endoscopic retrograde cholangiopancreatography (ERCP) was performed and revealed major dilation of the major and minor papillary orifices owing to presence of mucinous material. Sphincterotomy and use of a balloon inflated to 15 mm resulted in the clearance of the mucinous material. Cholangiography did not clearly identify a fistula between the bile duct and IPMN (▶ Video 1). The jaundice did not improve following this first procedure. A second ERCP was performed to extract mucinous material and to place two double-pigtail plastic stents (10 Fr × 7 cm) to provide biliary drainage (▶ Fig. 3).

Fistulization of IPMNs is a very rare complication, with only a few cases reported in the literature [2–5]. In practice, this type of fistula is untreatable by endoscopic means, mainly due to the continuous production of mucinous material. Endoscopic drainage appears to be a bridge to surgery or a palliative treatment. Surgery, when it is possible, appears to be the best treatment.

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The authors declare that they have no conflict of interest.

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References

Video 1 Endoscopic ultrasound and endoscopic retrograde cholangiopancreatography, showing dilation of the bile and pancreatic ducts by mucinous material, initial drainage, and subsequent placement of two double-pigtail plastic stents.

Fig. 2 Abdominal-pelvic computed tomography scan (coronal section) showing degenerated intraductal papillary mucinous pancreatic neoplasm (IPMN), biliary dilation, and possible fistula between the IPMN and main bile duct. a Degenerated IPMN (red arrow) and dilation of the main bile duct (green arrow). b Dilation of the main pancreatic duct (yellow arrow) due to the IPMN. c Probable fistula between the main bile duct and IPMN (red arrow), with dilation of the common bile duct (green arrow) and involvement of the pancreatic uncus by IPMN (blue arrow).
▶ Fig. 3  Endoscopic retrograde cholangiopancreatography. a Dilation of the intrahepatic bile ducts. b Two double-pigtail plastic stents were placed to provide biliary drainage.