

Severe acute pancreatitis following endoscopic biopsy of the minor duodenal papilla



Fig. 1 Contrast-enhanced computed tomographic (CT) imaging revealed pancreatic necrosis of more than 50% of the gland.

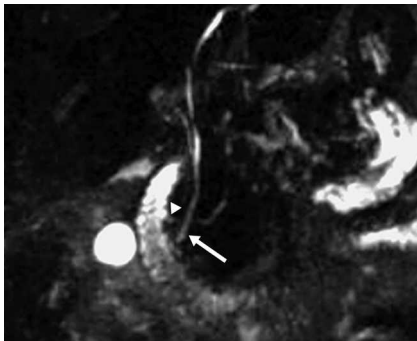


Fig. 3 Coronal magnetic resonance cholangiopancreatography imaging revealed pancreas divisum: the dorsal duct (arrowhead) draining independently into the first duodenum (minor papilla), superior and anterior to the common bile duct (arrow).

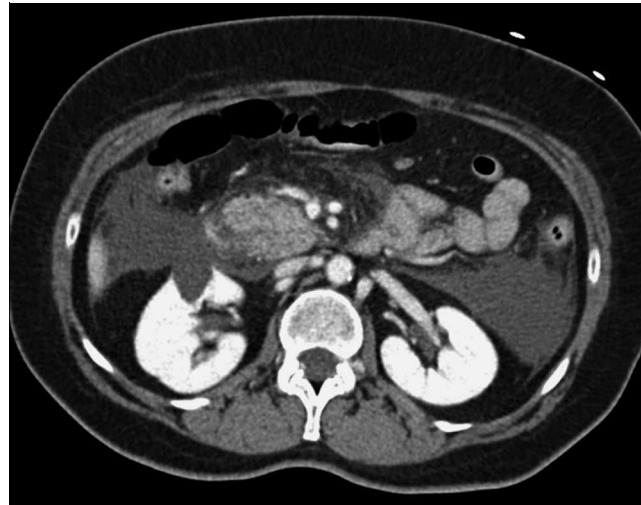


Fig. 2 Contrast-enhanced CT imaging revealed diffuse peri-pancreatic and bilateral parietocolic fat necrosis.



Fig. 4 CT imaging at 6 weeks shows a large pseudocyst measuring 13 × 8.5 cm at the level of the pancreatic body and tail.

A woman aged 57 was admitted with a 3-month history of moderate right upper quadrant abdominal pain. Abdominal ultrasonography revealed multiple solid liver nodules. Computed tomography (CT) of the thorax, abdomen, and pelvis confirmed liver metastases with no obvious primary tumor. Serum biochemistry showed only a mild increase in γ -glutamyl transpeptidase. Carcinoembryonic antigen and CA19–9 were increased to 60–80 times the normal values. Esophagogastroduodenoscopy revealed *Helicobacter pylori*-positive erosive gastritis and duodenal mucosal hyperplasia after biopsy of a suspiciously enlarged duode-

nal papilla. At the same time colonoscopy found the primary tumor – a 20-mm ulcerated adenocarcinoma in the left colon. Four hours after the endoscopy procedures, the patient complained of abdominal pain. Serum amylases, lipases, and C-reactive protein were increased to 20–30 times the normal values. CT scan showed grade E severe acute pancreatitis (Balthazar score) (► **Figs. 1** and **2**) [1]. The Ranson score was 6 at 48 hours after admission [2]. Magnetic resonance cholangiopancreatography diagnosed a complete pancreas divisum (► **Fig. 3**). After 4 weeks of intensive care the patient resumed normal alimentation. At 6

weeks a CT scan showed a large pseudocyst at the level of the pancreatic body and tail (► **Fig. 4**) and progression of liver metastasis. The patient was unresponsive to systemic chemotherapy. Two weeks later (8 weeks after the acute pancreatitis) the patient died from right atrial compression secondary to liver metastases. An asymptomatic rise in amylase concentration can be observed after 30% of papilla biopsies [3]. A single case of mild pancreatitis was reported after papilla biopsy in a patient with Gardner's syndrome [4]. Papillary edema due to biopsy may obstruct the pancreatic duct causing pancreatitis; this probably happens more

easily in the minor papilla in complete pancreas divisum [5]. As far as we know this is the first case of severe acute pancreatitis after duodenal papilla biopsy.

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