

Obstructive jaundice as a complication of a peptic duodenal ulcer mimicking pancreatic cancer

A 56-year-old man was admitted to our gastroenterology department for upper gastrointestinal bleeding. The patient was a heavy smoker and drank an average of 50 g of ethanol per day. On urgent upper endoscopy, an active bleeding ulcer was observed in the upper wall of the first duodenal flexure. In spite of therapeutic sclerosis with epinephrine 1:10000 (4 mL) and etoxiesclerol 2% (4 mL) the ulcer bled again. After a second unsuccessful attempt at therapeutic endoscopy with injection of epinephrine 1:10000 (6 mL) and etoxiesclerol 2% (4 mL) the patient was operated and the bleeding point sutured. After 2 months, the patient was readmitted for painless obstructive jaundice. An abdominal computed tomography (CT) scan showed dilated intra- and extrahepatic bile ducts (up to the intrapancreatic portion) and an increase in the size of the pancreatic head with an ill-defined hypodense area measuring 21 × 13 mm (● Fig. 1).

During endoscopic ultrasonography (EUS), a duodenal bulb ulcer with inflammation and mild stenosis of the duodenal flexure was observed. The EUS also revealed a lesion, 20 × 15 mm, with spiculated margins in the head of the pancreas and contiguous with the thickened duodenal wall (● Fig. 2).

Endoscopic biopsies and the cytologic examination of the material obtained by EUS-guided fine-needle aspiration were negative for malignant cells. Percutaneous cholangiography performed shortly afterward showed abrupt obstruction of the distal bile duct. Surgery was finally required to treat the biliary obstruction and a cephalic duodenopancreatectomy was performed. Histological study of the surgical specimen showed a duodenal ulcer with scarring retraction involving the pancreatic head and distal bile duct, but with no malignant infiltration (● Fig. 3). The postoperative course was favorable, and 3 months after the operation the patient was asymptomatic and generally well.

Obstructive jaundice secondary to a local pancreatic lesion has been related to malignant pancreatic tumors or to pseudotumors of inflammatory etiology, such as chronic pancreatitis [1]. Bile obstruction

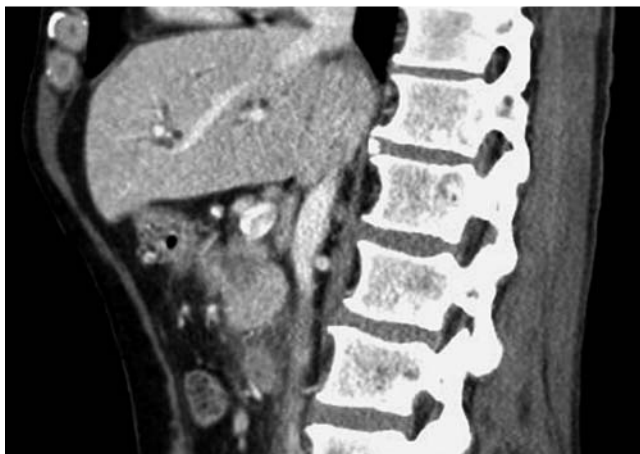


Fig. 1 A hypointense lesion visible in the pancreatic head on an abdominal computed tomography (CT) scan.

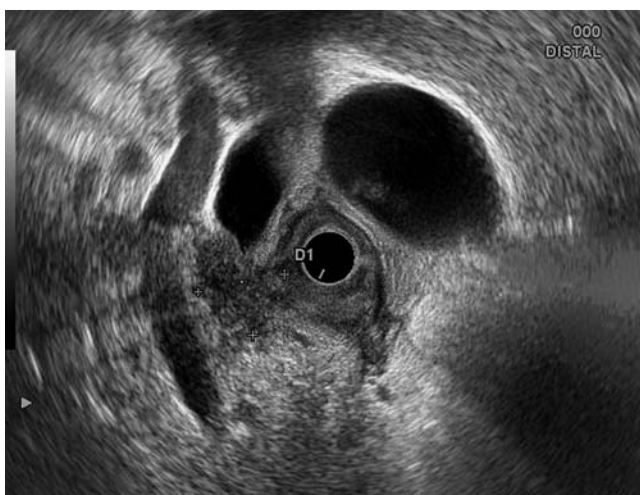


Fig. 2 A localized lesion visible in the pancreatic head on radial endoscopic ultrasonography. The lesion is contiguous with the thickened duodenal wall and is causing bile duct obstruction.

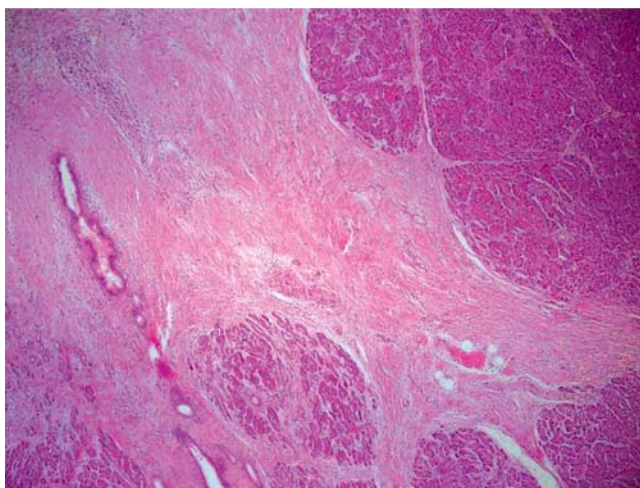


Fig. 3 Histological section showing pancreatic tissue replaced by fibrous scar retraction with starlike morphology mimicking an infiltrating tumor (hematoxylin and eosin, original magnification × 200).

as a complication of the treatment of a peptic ulcer is rare. Recently, this complication has been shown to be the result of a

peri-ulcerous inflammatory component [2] or the result of hemostatic treatment using sclerotic substances [3].

Competing interests: None

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