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 intrapancreatic segment (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 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].
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References

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