Acute pancreatitis due to an impacted juxta-papillary duodenal diverticulum

A 58-year-old woman presented with severe abdominal pain. Laboratory findings showed markedly raised amylase and lipase concentrations at 1169 IU/L and 5040 IU/L respectively. She denied any alcohol consumption. Triglyceride and calcium levels were within the normal range. An abdominal computed tomography (CT) scan showed a round, 2.7-cm, low density, mass-like lesion with a central area of air density in the second part of the duodenum and swelling of the adjacent pancreas. The common bile duct (arrow) and pancreatic duct (arrowhead) are seen above the lesion.

Fig. 1 Abdominal computed tomography (CT) scan showing a round, 2.7-cm, low density lesion with a central area of air density in the second part of the duodenum and swelling of the adjacent pancreas. The common bile duct (arrow) and pancreatic duct (arrowhead) are seen above the lesion.

The hard phytobezoar was broken up and removed using grasping forceps. After the bezoar had been removed, her pancreatitis improved.

A subsequent endoscopic retrograde cholangiopancreatography (ERCP) showed that the JPDD was located caudally to the papilla with the papillary orifice hardly visible, being located deep inside on the ceiling of the diverticulum. No biliary sludge or stones were noted. A sphincterotomy was performed to prevent recurrence of the pancreatitis (Fig. 3).

In this report, bezoar impaction in a rare caudally located type of JPDD caused acute pancreatitis. This is a rare cause of acute pancreatitis and an unusual clinical manifestation of a JPDD caused by its location.

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Competing interests: None

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Fig. 4 Diagram showing the anatomical relationships of a juxtapapillary duodenal diverticulum (JPDD) in: a the common type; b the atypical caudally located JPDD, which has more anatomical proximity to the pancreatic duct than to the common bile duct. (D, duodenum; BD, bile duct; PD, pancreatic duct; B, bezoar.)


Bibliography
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