Ascaris lumbricoides infestation is endemic in tropical countries. Most infections by A. lumbricoides are asymptomatic, but they can produce a wide spectrum of manifestations including hepatobiliary and pancreatic complications. Pancreatic ascariasis is a rare entity. In a study of 500 patients with hepatobiliary and pancreatic disease due to A. lumbricoides infection, only seven had pancreatic ascariasis [1], and there are few case reports of ascariasis-induced acute pancreatitis [2].

Mechanisms of acute pancreatitis associated with ascariasis include invasion of the pancreatic duct, the ampullary orifice, and both the common bile duct and the pancreatic duct [3]. Idiopathic pancreatitis is diagnosed when clinical, laboratory, and conventional radiologic methods do not provide a clear etiology for the episode. In the past, endoscopic retrograde cholangiopancreatography (ERCP) has been the imaging test of choice for evaluation of idiopathic recurrent acute pancreatitis, whereas now endoscopic ultrasonography (EUS) and magnetic resonance cholangiopancreatography (MRCP) are preferred, as they are more anatomically detailed and noninvasive.

Video 1

Endoscopic ultrasonography (EUS) was done for investigation of idiopathic recurrent acute pancreatitis in a 30-year-old man. Visualizations from the stomach, the descending duodenum, and the duodenal bulb, on clockwise and anticlockwise rotation of the probe, showed features of the ascaris infestation. Side-viewing endoscopy showed two worms in the duodenal lumen, one extruding from the papilla; these were removed using biopsy forceps.
ography (MRCP) are advocated as safer options [4]. However, EUS should be considered as the first investigation for evaluation of idiopathic pancreatitis [5].

A 30-year-old man presented with idiopathic recurrent acute pancreatitis that had been occurring in the previous 8 months. Abdominal ultrasonography showed a bulky pancreas and MRCP findings were normal. Linear EUS was performed for evaluation of idiopathic recurrent acute pancreatitis. The pancreas was enlarged and hypoechoic, suggestive of acute pancreatitis. EUS revealed linear, nonshadowing, echogenic strips in a dilated pancreatic duct (Fig. 1 a, Fig. 1 b and Video 1). An ascaris worm was seen as a linear shadow with two hyperchoic linear echogenic strips on either side of the longitudinal anechoic lumen (Fig. 1 c). Side-viewing endoscopy showed two worms in the duodenal lumen with one extruding from the papilla. The worms were removed with a biopsy forceps (Fig. 2). They were 29 cm and 22 cm in length (Fig. 3) and identified as A. lumbricoides. The patient underwent deworming with albendazole and was followed up for 6 months with no further episodes of acute pancreatitis.

To conclude, pancreatic ascariasis should be considered as a possible cause of idiopathic pancreatitis.

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