Endoscopic ultrasonography imaging of pancreatic duct ascariasis

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 cholangiopancrea-

Fig. 1 Endoscopic ultrasonography (EUS) was done for investigation of idiopathic recurrent acute pancreatitis in a 30-year-old man. A linear echogenic shadow was seen in the pancreatic duct within the head of the pancreas. EUS from the duodenal bulb demonstrated the ascaris worm in the head of the pancreas. EUS from the descending duodenum showed a linear shadow with two hyperechoic linear echogenic strips on either side of the longitudinal anechoic lumen of the ascaris worm.

Fig. 2 Side-viewing endoscopy showed two ascaris worms in the duodenal lumen; one was extruding from the papilla. They were removed with biopsy forceps.

Fig. 3 Two creamy white roundworms seen after removal.
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. 1a, Fig. 1b and Video 1). An ascaris worm was seen as a linear shadow with two hyper-echoic linear echogenic strips on either side of the longitudinal anechoic lumen (Fig. 1c). 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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