Biopsy of pancreas allografts has a critical role in the evaluation of pancreas allograft dysfunction [1]. However, percutaneous ultrasound or computed tomography (CT)-guided biopsy of a pancreas allograft in the pelvis may not be feasible in some cases. Pelvic lesions are easily imaged endosonographically from the rectum or distal sigmoid colon. Although transrectal endoscopic ultrasonography (EUS)-guided biopsy or drainage for pelvic lesions has been demonstrated to be feasible and safe [2,3], there have been no reports of lower gastrointestinal EUS-guided biopsy (FNB) of a pancreas allograft in the pelvis owing to the unique anatomic configuration of the post-transplant anatomy [4]. A 47-year-old man underwent simultaneous pancreas and kidney transplantation 10 years ago for insulin-dependent diabetes mellitus and end-stage renal disease due to diabetic nephropathy. The graft duodenum had been anastomosed to the proximal jejunal to allow for enteric exocrine drainage. The patient presented to us with right lower abdominal pain and elevated levels of amylase and lipase. His abdominopelvic CT scan showed swelling of the pancreas allograft with pancreatic duct dilatation and peripancreatic infiltration (Fig. 1). Given this picture, histologic evaluation of the pancreas allograft was mandatory, but the direction of its body and tail, placed towards the right pelvis, was not suitable for percutaneous access. Therefore, we decided to perform a trans-sigmoidal EUS-guided FNB. The procedure was performed after the patient had undergone bowel preparation. A linear echoendoscope was rotated counter-clockwise in the distal sigmoid colon, and the pancreas allograft was visualized in the right pelvis. Trans-sigmoidal EUS-FNB was performed with a 22-gauge needle (ProCore Needle; COOK Medical) using the stylet slow-pull technique for a pancreas allograft. A total of four needle passes were made and no procedure-related adverse events were seen. The biopsy revealed monomorphic-type post-transplant lymphoproliferative disorder consistent with Burkitt lymphoma based on histological, immunohistochemical, and fluorescence in situ hybridization (FISH) analysis (Fig. 3). After receiving the first cycle of hyper-fractiated cyclophosphamide, vincristine, doxorubicin, and dexamethasone (Hyper-CVAD), the patient’s lower abdominal pain and elevated pancreatic enzymes were improved.

Competing interests
None
The Authors

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References


Bibliography

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