A 50-year-old woman was admitted with a history of melena in the last 24 h. She reported having suffered intermittent mild mid-epigastric pain, postprandial nausea, and bilious emesis during the past 3 months. She was taking nonsteroidal anti-inflammatory drugs up to 1200 mg per day. On examination she was pale, afebrile, with a regular heart rate at 100 beats/min and a blood pressure of 110/60 mm Hg. She had abdominal tenderness with no signs of guarding. Laboratory data showed the hemoglobin concentration at 7 g/dL and leukocytosis (23 × 10⁹/L). Plain abdominal and chest radiographs were normal. After stabilization, gastroscopy revealed a large duodenal ulcer covered by a nonremovable blood clot and oozing that was effectively controlled by injection therapy with ethanolamine. After endoscopy the patient was in severe pain, and a CT scan of the abdomen revealed pneumopancreas (Fig. 1). She responded promptly to conservative medical therapy. The follow-up CT 14 days later showed a marked reduction of pneumopancreas, with a thin, air-filled fistulous tract between the gastric lumen and the pancreatic duct (Fig. 2). Complete healing of the ulcer was achieved with antisecretory therapy. The patient presented 3 months later with jaundice as a result of stricture of the distal common bile duct. Surgical hepaticojejunostomy was performed and she recovered uneventfully and is cholangitis-free, 1 year after the operation.

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Fig. 1 Contrast-enhanced CT scan of the abdomen revealed a markedly distended gas-filled pancreatic duct, with no inflammatory changes in the pancreas, peripancreatic collections, or pneumoperitoneum.

Fig. 2 Follow-up CT 14 days later showing a marked reduction of pneumopancreas and loss of fascial planes, with a thin, air-filled sinus tract (white arrow) between the adjacent bowel wall and the head of the pancreas.