Endoscopic ultrasonography (EUS) is now a widely accepted modality for visualizing pancreatic lesions, and EUS-guided fine-needle aspiration (EUS-FNA) appears to be a safe and effective method for establishing the histological diagnosis of pancreatic tumors [1–3]. However, it is sometimes difficult to obtain samples from very small targets, especially tumors of 1 cm or less. We report a case in which EUS-FNA was useful for the diagnosis of in situ carcinoma of the pancreas. A 65-year-old patient was admitted to our hospital because of dilatation of the main duct in the pancreatic body as seen on transabdominal ultrasonography. Serum carcinoembryonic antigen and carbohydrate antigen 19–9 levels were within normal limits. Computed tomography and magnetic resonance cholangiopancreatography (MRCP) revealed mild dilatation of the main pancreatic duct (Fig. 1). During endoscopic retrograde pancreatography, deep cannulation proved impossible due to severe stricture of the pancreatic duct, and therefore no adequate sample of pancreatic juice could be obtained. EUS showed an echogenic structure 3 mm in diameter in the pancreatic duct (inside white dashed outline). This lesion is consistent with the ductal stenosis observed by MRCP. MPD: main pancreatic duct. EUS-FNA was performed for a histological diagnosis of the echogenic structure in the pancreatic duct. The cytological examination demonstrated clusters of atypical cells consistent with adenocarcinoma (Fig. 3). The histopathological examination of the pancreas achieved by pancreatic duodenectomy revealed intraductally spreading carcinoma in the main duct of the pancreatic head. Red areas: inflammatory changes in the pancreas; arrows: pancreatic ducts (main and branch).
showed an intraductally spreading carcinoma that was 8 mm in maximum length, 3 mm in diameter, in the main duct of the pancreatic body. The histopathological diagnosis was in situ carcinoma of the pancreas (Fig. 4 – 6).

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