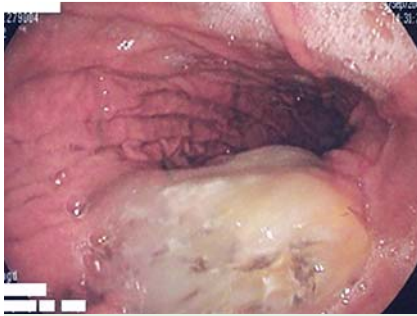


## Pancreatic cystic neoplasm presenting as a large gastric ulcer

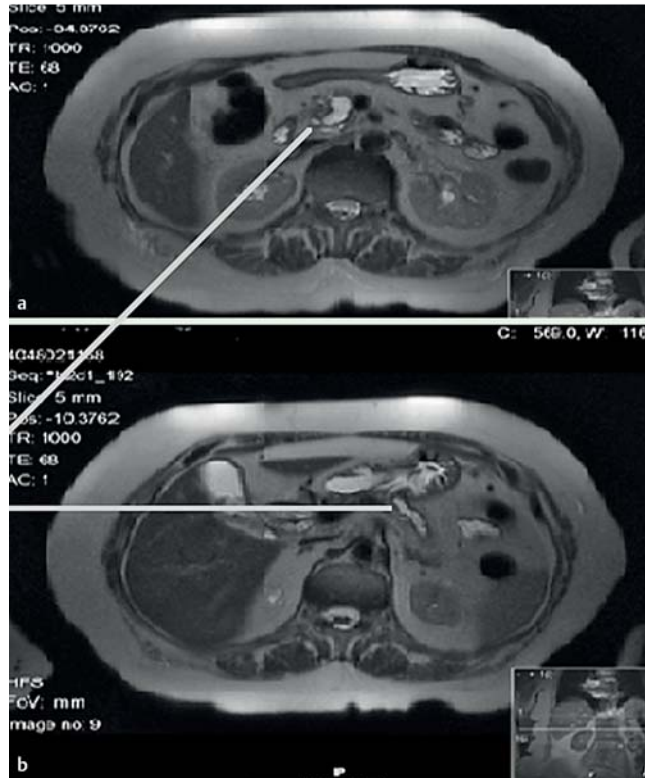


**Fig. 1** Esophagogastroduodenoscopy showing a large, mucus-secreting gastric ulcer.

An 85-year-old woman was admitted with painless obstructive jaundice that had developed over the previous few weeks. Ultrasound examination showed intrahepatic and extrahepatic duct dilatation; the common bile duct (CBD) measured 2.5 cm, and there was a suggestion of pancreatic duct dilatation. A few gallstones were identified in an otherwise normal-looking gallbladder, but no obstructing CBD stones were seen. The dilated biliary system was confirmed by endoscopic retrograde cholangiopancreatography (ERCP); no stones were identified in the CBD, but a copious amount of mucus was cleared from the duct. A large gastric ulcer was also noted at ERCP, which was confirmed on formal gastroduodenoscopy and was also seen to be secreting thick mucus into the stomach (● **Fig. 1**).

A computed tomography (CT) scan showed a cystic pancreatic mass, and on magnetic resonance cholangiopancreatography (MRCP) the dilated pancreatic duct was seen to form a connection to the stomach (● **Fig. 2**).

Gastric ulcer biopsies showed fragments of a severely dysplastic villous tumour, but biliary brushings were inconclusive. An endoscopic ultrasound (EUS) with fine needle aspiration was performed, which confirmed the eventual diagnosis of a mucinous cystadenoma of the pancreas with a fistulating gastric metastasis. There were extensive discussions with the patient and her daughter about further treatment options, but clinically she had



**Fig. 2** Magnetic resonance cholangiopancreatography (MRCP) showing: **a** the dilated pancreatic duct that had formed a fistula; **b** the stomach with the other end of the fistula.

become very frail, experiencing further bouts of cholangitis that required insertion of a metal stent, so the multidisciplinary decision was for palliative management.

Differentiation of pancreatic cysts between benign and malignant causes can be difficult, requiring a combination of clinical, radiological, and histological approaches [1]. The fistula seen in this case between the mucinous cystadenoma and the stomach wall represents a rare finding, not being a previously reported feature of pancreatic cystic neoplasms.

Endoscopy\_UCTN\_Code\_CCL\_1AB\_2AD\_3AC

**Competing interests:** None

**S. Mathew, S. Gupta, M. Mendall, D. Sarma**

Department of Gastroenterology, Croydon University Hospital, UK

### References

- 1 Khalid A, Brugga W. ACG Practice guidelines for the diagnosis and management of neoplastic pancreatic cysts. *Am J Gastroenterol* 2007; 102: 2339–2349

### Bibliography

DOI 10.1055/s-0030-1256644

Endoscopy 2011; 43: E363

© Georg Thieme Verlag KG Stuttgart · New York · ISSN 0013-726X

### Corresponding author

**S. Mathew, MD**

Department of Gastroenterology, Croydon University Hospital

Croydon

CR7 7YE

UK

Fax: +020-8401-3495

sanjumathe@doctors.org.uk