

An unusual pancreatic lesion causing biliary obstruction and duodenal invasion



Fig. 1 An 84-year-old woman was admitted with melena. **a** CT imaging revealed a complex cystic pancreatic head mass with multiple internal septations. **b** CT angiography reconstruction imaging showed a large hypervascular pancreatic lesion.

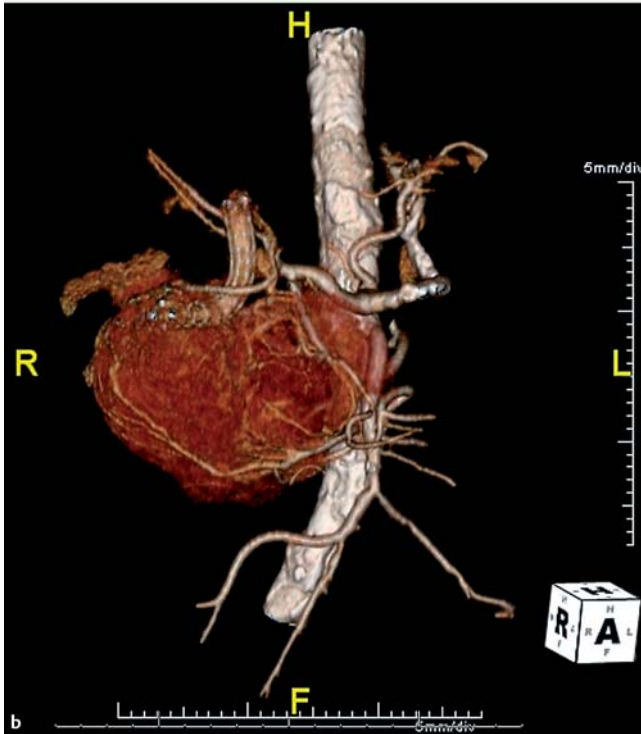


Fig. 2 Endoscopy revealed ulceration consistent with duodenal invasion.

An 84-year-old woman was admitted with melena. She had had an enlarging pancreatic mass 2 years earlier requiring endoscopic retrograde cholangiopancreatography (ERCP) with sphincterotomy and biliary metal stent placement. Her current presentation included melena for 1 week. She did not have any pain, nausea, vomiting, abdominal fullness or weight loss. Vital signs were within normal limits. On physical examination, mild epigastric tenderness was present. Laboratory studies revealed hemoglobin of 6.6 g/dL, a normal comprehensive metabolic profile, and nor-

mal serum lipase. Computed tomography (CT) imaging revealed a 10.9×8.2 cm complex heterogeneously enhancing cystic pancreatic head mass with multiple internal septations (● Fig. 1 a). CT angiography reconstruction imaging showed a hypervascular pancreatic mass (● Fig. 1 b). Endoscopy revealed friable duodenal mucosa from duodenal infiltration (● Fig. 2). Cytologic examination through endoscopic ultrasound (EUS)-guided fine-needle aspiration showed scant cellularity. The patient was diagnosed with serous cystadenoma of the pancreas, although evolu-

tion to cystadenocarcinoma could not be excluded. Prophylactic embolization of the gastroduodenal and inferior pancreaticoduodenal arteries was performed. The patient was doing well at the time of last follow-up.

Serous cystadenomas are benign tumors and represent about 30% of primary cystic neoplasms of the pancreas [1]. While some patients are asymptomatic at the time of diagnosis, most present with abdominal pain, abdominal fullness/mass, jaundice or weight loss [2]. Duodenal wall invasion with erosion and bleeding as seen in our case is a rare presentation of this benign lesion. A high degree of diagnostic reliability is crucial in differentiating serous cystadenoma from serous cystadenocarcinoma, mucinous cystadenoma, intraductal papillary mucinous neoplasms, or a pancreatic pseudocyst. CT imaging, abdominal ultrasonography, and endoscopic ultrasound are usually diagnostically sufficient although cyst fluid analysis can be helpful [2].

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Competing interests: None

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