Intraductal papillary mucinous pancreatic neoplasms (IPMNs) are very common lesions. International guidelines recommend surveillance or more invasive management according to precise criteria [1]. A very rare complication of these lesions is the fistulization to an adjacent structure of the pancreas [2, 3].

We report the case of a 90-year-old man with jaundice in the context of metastatic prostatic adenocarcinoma. A cephalic cystic lesion of the pancreas was known and stable during his oncologic follow-up. An abdominal-pelvic computed tomography scan found major dilation of the common bile duct (measuring 27 mm) and of the main pancreatic duct (12 mm). A cephalic multiloculated cystic mass was also described, measuring 77 × 78 mm with irregular parietal nodular contrast, compatible with IPMNs (▶Fig. 1, ▶Fig. 2).

Endoscopic ultrasonography confirmed the diagnosis of IPMN with high-risk stigmata (main pancreatic duct > 10 mm and enhancing mural nodule > 5 mm). Endoscopic retrograde cholangiopancreatography (ERCP) was performed and revealed major dilation of the major and minor papillary orifices owing to presence of mucinous material. Sphincterotomy and use of a balloon inflated to 15 mm resulted in the clearance of the mucinous material. Cholangiography did not clearly identify a fistula between the bile duct and IPMN (▶Video 1). The jaundice did not improve following this first procedure. A second ERCP was performed to extract mucinous material and to place two double-pigtail plastic stents (10Fr × 7 cm) to provide biliary drainage (▶Fig. 3).

Fistulization of IPMNs is a very rare complication, with only a few cases reported in the literature [2–5]. In practice, this type of fistula is untreatable by endoscopic means, mainly due to the continuous production of mucinous material. Endoscopic drainage appears to be a bridge to surgery or a palliative treatment. Surgery, when it is possible, appears to be the best treatment.

Endoscopy_UCTN_Code_CCL_1AZ_2AM
The authors

Pierre Mayer1,2, Lucile Héroin1,2, Leonardo Sosa-Valencia2, Flavien Dautrecque1, Patrick Pessaux2,4,5, Antonio Saviano1,2,5, François Habersetzer1,2,5
1 Department of Hepatology and Gastroenterology, Pôle Hépato-digestif, Nouvel Hôpital Civil, Hôpitaux Universitaires de Strasbourg, Strasbourg, France
2 Institut Hospitalo Universitaire Strasbourg, Strasbourg, France
3 Department of Hepatology and Gastroenterology, Centre Hospitalier de Lens, Lens, France
4 Department of Visceral and Digestive Surgery Pôle Hépato-digestif, Nouvel Hôpital Civil, Hôpitaux Universitaires de Strasbourg, Strasbourg, France
5 Inserm U1110, Institute for Viral and Liver Diseases, LabEx HepSYS, University of Strasbourg, Faculty of Medicine, Strasbourg, France

Corresponding author
Pierre Mayer, MD
Department of Hepatology and Gastroenterology, Pôle Hépato-digestif, Nouvel Hôpital Civil, Hôpitaux Universitaires de Strasbourg (HUS), 1, place de l’Hôpital, 67000 Strasbourg, France
pierre-emmanuel.mayer@chru-strasbourg.fr

References


Acknowledgment

This work was supported by French state funds managed within the “Plan Investments d’Avenir” and by the ANR (reference ANR-10-IAHU-02). This work has been published under the framework of the LABEX ANR-10-LABX-0028_HEPSYS and Inserm Plan Cancer and benefits from funding from the state managed by the French National Research Agency as part of the Investments for the future program.

Funding

Agence Nationale de la Recherche
http://dx.doi.org/10.13039/50110001665 ANR-10-IAHU-02

Competing interests

The authors declare that they have no conflict of interest.
Fig. 3  Endoscopic retrograde cholangiopancreatography. a Dilation of the intrahepatic bile ducts. b Two double-pigtail plastic stents were placed to provide biliary drainage.