A 71-year-old man was referred to our hospital with chronic alcoholic pancreatitis. He had a history of daily intake of alcohol and intermittent abdominal pain over the past 15 years. The biochemical tests were normal except for a mild increase in the gamma glutamyl transpeptidase level. Cancer antigen (CA) 19–9 was 118.1 U/mL (normal value < 27 U/mL). Abdominal computed tomography scan showed an enlarged pancreatic head with calcifications, a marked dilated upstream pancreatic duct, and parenchymal atrophy (Fig. 1 a and Fig. 1 b).

Magnetic resonance cholangiopancreatography also revealed intraductal filling defects in the dilated pancreatic duct (Fig. 2). Under the impression of chronic pancreatitis with massive pancreaticolithiasis, endoscopic retrograde cholangiopancreatography was performed. The major papilla was slightly enlarged, and yellowish mucin-like material was noted at the orifice (Fig. 3 a). We initially thought that this material might be bile-tinged, fragmented pancreatic duct stones because the patient had a massive pancreaticolithiasis. However, endoscopic pancreatic sphincterotomy revealed it to be an intra-ampullary soft mass protruding from the pancreas head (Fig. 3 b). A biopsy was performed and the pathology revealed a mucinous carcinoma with well-defined pools of mucin and malignant epithelial cells (Fig. 4).

Mucinous carcinoma of the pancreas is rare and is characterized histologically by lakes of extracellular mucin with “floating” malignant epithelial cells. Grossly, the mass is gel-like, soft, and movable [1]. This characteristic pathological finding, of the tumor in this case, might have affected the peculiar endoscopic finding and unusual location (i.e. the protruding mass in the ampullary portion of the papilla). Fortunately, we could diagnose the pancreatic cancer that had not been seen on the radiologic studies when performing the pancreatic sphincterotomy, which is known to be an essential step for endoscopic intervention of chronic pancreatitis, especially for stone removal [2].
E. J. Lee\textsuperscript{1}, K. R. Joo\textsuperscript{1}, J. M. Cha\textsuperscript{1}, H. P. Shin\textsuperscript{1}, S. W. Jung\textsuperscript{1}, J. I. Lee\textsuperscript{1}, G. Y. Kim\textsuperscript{2}\textsuperscript{1} Department of Internal Medicine, Kyung Hee University East-West Neo Medical Center, Seoul, Korea
\textsuperscript{2} Department of Pathology, Kyung Hee University East-West Neo Medical Center, Seoul, Korea

References

Bibliography
Endoscopy 2009; 41: E74 – E75
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author
K. R. Joo, MD
Department of Internal Medicine
Kyung Hee University East-West Neo Medical Center
149 Sangil-dong Gangdong-gu
Seoul, 134-090
Korea
Fax: +82-2-4406295
krjoo@khu.ac.kr

Fig. 3  \textbf{a} Duodenoscopy shows a bulging major papilla with yellowish, mucin-like material at the orifice. \textbf{b} After the pancreatic sphincterotomy, a reddish and friable soft mass is detected at the ampullary portion of the papilla.

Fig. 4 Pathology reveals mucin pools with floating malignant epithelial cells, consistent with the diagnosis of mucinous carcinoma (hematoxylin and eosin, ×400).

Endoscopy 2009; 41: E74 – E75