A 58-year old woman presented with constant epigastric abdominal pain radiating to her back, of 1 week’s duration. The patient had associated nausea, vomiting, anorexia, and weight loss. Physical examination revealed midepigastric tenderness without a palpable mass. Pertinent laboratory values included serum amylase of 410 units/L and lipase of 471 units/L. Abdominal computed tomography (CT) scan revealed a 6-cm cystic mass between the stomach and pancreas, as well as mild pancreatitis (Fig. 1). Upper endoscopy showed extrinsic compression of the stomach along the lesser curvature, prohibiting passage of the scope to the pylorus. Endoscopic ultrasound revealed a 6 × 6-cm heterogeneous, well-rounded mass with calcifications and a calcified rim originating from the gastric mucosa, along with upstream dilation of the pancreatic duct to 1 cm (Fig. 2). Fine-needle aspiration revealed spindle cells. During surgery, a well-rounded mass originating from the gastric antrum was found to have prolapsed into the second portion of the duodenum, obstructing the pancreatic duct. The patient underwent a partial resection of the anterior gastric wall. Final surgical pathology revealed diffuse c-kit positivity, confirming the mass was a gastrointestinal stromal tumor (GIST). Post-operatively, the patient’s pancreatitis resolved, and she has not had a recurrence of her pancreatitis.

Although there are reports of duodenal GISTs mimicking pancreatic cancer, there are no known reports where acute pancreatitis (fulfilling two of three criteria) is secondary to a GIST [1]. In conclusion, we report a rare case of gastrointestinal stromal tumor presenting as acute pancreatitis, which, to our knowledge, is the first reported case in the literature.

Competing interests: None

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