Recurrent pancreatitis caused by pancreatic ductal villous adenoma treated with endoscopic snare polypectomy

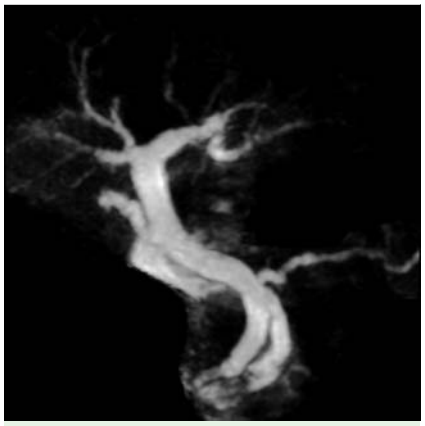

Fig. 1 Magnetic resonance cholangiopancreatography (MRCP) in a 70-year-old white man with recurrent acute pancreatitis showing the bile and pancreatic ducts. The main pancreatic ductal dilation is noted with an irregular filling defect within.

Fig. 2 Fluoroscopic image at endoscopic retrograde cholangiopancreatography (ERCP) confirms the filling defect in a dilated pancreatic duct.

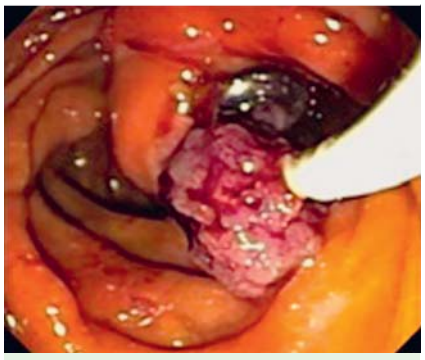

Fig. 3 Endoscopic view of balloon adenoma "extraction" following pancreatic sphincterotomy.

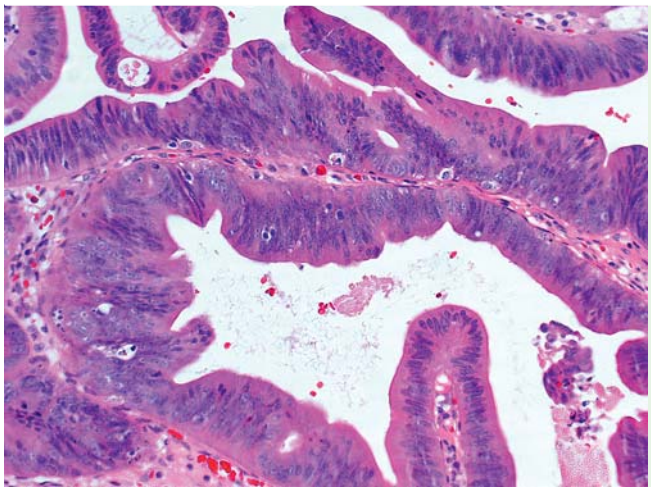

Fig. 4 Histological section of the resection specimen depicting villous fronds and high grade dysplasia (hematoxylin and eosin, magnification × 20).

Adenomas can develop anywhere along the gastrointestinal tract. Herein we describe pancreatic ductal adenoma causing recurrent pancreatitis treated by endoscopic snare polypectomy.

A 70-year-old white male with recurrent acute pancreatitis (index attack 5 years ago) was referred for endoscopic ultrasound (EUS) and endoscopic retrograde cholangiopancreatography (ERCP) evaluation. The latest magnetic resonance scan showed a pancreatic ductal filling defect with ductal dilatation (▶ **Fig. 1**). Linear array EUS examination revealed a 1.5 × 1.6 cm submucosal, mixed echogenic mass lesion causing upstream pancreatic ductal dilation. The common bile duct was of normal caliber with no filling defects. ERCP confirmed a bulging ampulla and pancreatogram (▶ **Fig. 2**) established the dilated pancreatic duct with an irregular, mobile filling defect. Following pull-type pancreatic sphincterotomy, balloon extraction exposed a floppy, exuberant, irregular, adenomatous appearing polyp arising from the inferior wall of the pancreatic duct (▶ **Fig. 3**). Standard snare polypectomy was carried out with blended current and a 5-Fr pancreatic ductal stent was placed (▶ **Video 1**). Histological assessment of the resected specimen revealed a villous adenoma with focal high grade dysplasia (▶ **Fig. 4**). The patient continues to do well with no further episodes of pancreatitis.

Pancreatic ductal polyps are rare with few case reports in the literature [1, 2]. Clinical

Video 1

The technique of pancreatic ductal polypectomy.

presentations include mass lesions in the pancreas and recurrent acute pancreatitis. Intraductal papillary mucinous neoplasm is a much more common cause of ductal dilation and pancreatitis with progression to adenocarcinoma. This patient, however, presented with a villous adenoma of the pancreatic duct causing recurrent acute pancreatitis. These lesions appear to follow the adenoma-carcinoma pathway [3,4] seen in the colon and therefore need removal. Transduodenal local excision of pancreatic ductal adenoma has been described before [5] but this is the first report describing potentially curative, endoscopic polypectomy of a ductal adenoma. Our patient remains under regular surveillance with follow-up ERCP for stent removal and reevaluation of the pancreatic duct.

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Competing interests: None

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