Identification of intraductal papillary mucinous neoplasm by esophagogastroduodenoscopy

Some reports have described identification of intraductal papillary mucinous neoplasm (IPMN) penetrating to the stomach by esophagogastroduodenoscopy (EGD) [1–4]. However, it seems that detecting an IPMN from within a postoperative pancreatogastric fistula is very rare. A 71-year-old man presented with slight fever. He had a history of acute pancreatitis and underwent cystogastrostomy for pancreatic pseudocyst at another institution 8 years earlier. IPMN had not been detected at that time. A detailed examination was carried out, including computed tomography (CT), which revealed a large cystic tumor in the head of the pancreas. A pancreatogastric fistula is present within the posterior wall of the stomach.

Fig. 1 Contrast-enhanced computed tomography (CT) in a 71-year-old man with mild fever and a history of acute pancreatitis. There is a large cystic tumor in the head of the pancreas. A pancreatogastric fistula is present within the posterior wall of the stomach.

Fig. 2 Magnetic resonance cholangiopancreatography showing cystic tumor in the head of the pancreas without dilatation of the main pancreatic duct.

Fig. 3 Endoscopic view of the pancreatogastric fistula.

On passing the scope through the fistula a protruding papillary tumor covered with mucus was noted (Fig. 4). Biopsy samples were obtained and histological examination revealed high-grade tubular adenoma. Pancreatoduodenectomy was subsequently carried out and the patient was diagnosed as having branch-type IPMN containing foci of well-differentiated tubular adenocarcinoma (Fig. 5). There was no evidence of local invasion or metastasis.

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Competing interests: None

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Fig. 4 Endoscopic views. a After passage through the fistula. b Tumor after irrigation.

Fig. 5 Histological section of the resected specimen showing a well-differentiated tubular adenocarcinoma.