A 72-year-old man was evaluated because of epigastric abdominal pain and jaundice. His medical history included partial gastrectomy performed for peptic ulcer disease. Physical examination revealed jaundice and an epigastric mass, with tenderness of the upper abdomen. Magnetic resonance imaging revealed a large, mixed cystic and solid mass at the level of the pancreatic head measuring $6.8 \times 5.4$ cm. The mass resulted in superior mesenteric vein retraction and superior mesenteric artery distortion. There were also multiple pancreatic cysts, suggesting intraductal papillary mucinous neoplasia. In addition, various hepatic nodules were present, as well as enlarged peripancreatic lymph nodes. A positron emission tomography–computed tomography scan revealed uptake by the pancreatic mass, lymph nodes, and multiple hepatic masses (Fig. 1). An abdominal ultrasound-guided biopsy of a liver mass confirmed metastatic adenocarcinoma. Because of diffuse disease the patient was referred for palliative biliary endoscopic drainage. During endoscopic retrograde cholangiopancreatography, the minor papilla showed a typical “fish-mouth” aspect (Fig. 2). A pancreatogram revealed dorsal duct dilation and several filling defects (Fig. 3). Contrast injected into the major papilla showed a very small and thin pancreatic ventral duct, and a tight distal biliary stricture due to malignant compression by the pancreatic neoplasia (Fig. 4). A partially covered metallic stent ($1 \times 6$ cm) was inserted (Fig. 5).
Jaundice improved and serum total bilirubin returned to normal (1.2 mg/dL) 10 days after the procedure. The patient then started chemotherapy treatment.

Competition interests: None

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