Endoscopic management of obstructive pancreatitis with a metal stent in two family members with hereditary cationic trypsinogen (PRSS1) deficiency

We report here the case of a 37-year-old woman and her daughter (now 12 years old) with genetically proven hereditary cationic trypsinogen (PRSS1) deficiency pancreatitis. The two patients were treated in a similar manner: endoscopic extraction of large obstructive stones located mainly in the head of the pancreas upstream of a stricture of the distal (cephalic) pancreatic duct and associated with extreme dilation (10–15 mm) of the pancreatic duct, manifesting as bouts of mild acute pancreatitis and abdominal pain that could not be relieved with analgesics (Fig. 1–3).

Both patients underwent pancreatic sphincterotomy, hydrostatic dilation of the pancreatic duct stricture with a 6-mm Hurricane RX Biliary Dilation Balloon (Boston Scientific, Natick, Massachusetts, USA), removal of the stone fragments with a Dormia basket, and placement of an 8-mm-diameter, 60-mm-long fully covered self-expandable metal stent (SEMS) (WallFlex Biliary RX Stent; Boston Scientific, Natick, Massachusetts, USA), which was withdrawn 3 months later. Since this procedure, the daughter has remained asymptomatic and has resumed school attendance uneventfully.

Optimal stenting modalities have not been detailed in the rare reports devoted to patients with this condition [1–5]. The use of fully covered SEMS was of particular interest in these two patients, who presented with similar findings (short distal stricture and unusually large upstream dilation), because these stents can facilitate the removal of large stones and reduce the discrepancy between duct size in the head and body of the pancreas, a major factor in stone formation.

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