

Recurrent Pancreatitis in a 16-Year-Old Patient[☆]



Pancreatitis de repetición en paciente de 16 años

The prevalence of duodenal diverticula in the population varies from 0.16% to 22%.¹ Generally, the presentation is asymptomatic and the finding is incidental during imaging tests. When diverticula cause symptoms, these usually include hemorrhage, diverticulitis, formation of bezoars, obstruction, perforation, pancreatitis, extrinsic compression of the bile ducts or cholangitis.^{2,3}

We present the case of a 16-year-old patient with no medical history of interest who came to our emergency department on successive occasions due to epigastric pain. The patient was diagnosed with acute pancreatitis and hospitalized for further studies. Abdominal ultrasound and magnetic resonance cholangiography were normal. Gastrointestinal transit test showed evidence of an intraluminal duodenal diverticulum that occupied the lumen from the knee of the duodenum up until the third portion. Gastroscopy confirmed the existence of the diverticulum situated close to the major papilla. The patient was scheduled for surgery, which included duodenotomy, diverticulectomy, and hemostatic suture. Postoperative evolution was favorable, and the patient was discharged from the hospital on the eighth day after the procedure.

Discussion

Duodenal diverticula are congenital in young patients and acquired in adults. The congenital types are usually true diverticula and contain all the layers of the duodenal wall, while the acquired ones are usually false (herniations of the duodenal mucous membrane through the muscular layer).



Fig. 1 – Surgical procedure.

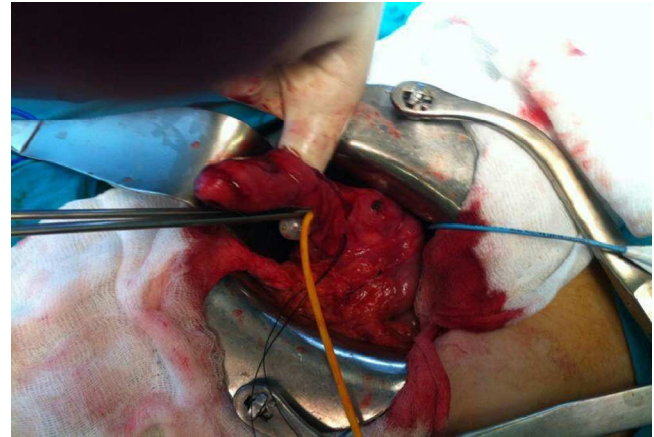


Fig. 2 – Gastrointestinal series.

They can present in the second, third or fourth portion of the duodenum, with a preference for the second.⁴ Only 10% cause symptoms.⁵ In our case, possibly the accumulation of intestinal material in the diverticulum was the cause of the compression of the pancreatic duct or the bile duct, causing recurrent pancreatitis.⁶ Another cause is the colonization of the diverticulum by bacteria that produce beta-glucuronidases, favoring the formation of calcium bilirubinate. The therapeutic possibilities in cases of duodenal diverticula that cause pancreatitis symptoms are endoscopic resection, diverticulectomy by laparotomy or laparoscopy⁷ or biliary enteric bypass by means of Roux-en-Y hepaticojejunostomy.⁸ The possibility of an intraluminal duodenal diverticulum should be considered in the differential diagnosis in cases of pancreatitis with unknown etiology or in very young patients (Figs. 1 and 2).

Conflict of Interests

The authors declare that there is no conflict of interest.

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A Young Woman With a Pancreatic Head Cystic Neoplasm[☆]



Mujer joven con tumoración quística en la cabeza pancreática

Solid pseudopapillary tumors (SPT) represent 1%-2% of pancreatic tumors.¹ Described by Frantz in 1959,² they have received several names: Frantz tumor, Hamoudi tumor, solid cystic pancreatic tumor or papillary epithelial neoplasm. In 1996, the WHO established their denomination as solid pseudopapillary tumor of the pancreas.³

The epidemiology of this neoplasm is very characteristic, appearing almost exclusively in young women in their second to third decades of life.^{1,4,5} It is usually an incidental finding on imaging studies that are ordered for other reasons. In spite of the fact that 15% of cases can present metastatic dissemination, it is considered a tumor with a low potential for malignancy, with overall survival rates of more than 95% and a recurrence rate lower than 10%.^{4,5}

We present the clinical case of a 23-year-old woman with no history of interest who consulted for abdominal pain in the right iliac fossa. Physical examination as well as the basic work-up presented no alterations. Abdominal CT showed thickening that was inflammatory in appearance in the terminal ileum and a 4-cm mass with well-defined margins and a cystic appearance in the head of the pancreas (Fig. 1). The study was completed with a colonoscopy, that was normal, and an endoscopic ultrasound with needle aspiration of the pancreatic lesion. The result of the cytology was not

conclusive and the suctioned liquid contained a concentration of carcinoembryonic antigen of less than 2 ng/ml.

With the clinical and radiological suspicion of a pancreatic SPT, the neoplasm was resected by means of pancreaticoduodenectomy with resection of the pylorus (Fig. 2), followed by a Child's reconstruction. The postoperative period transpired without complications.

The pathology report corroborated the diagnosis of pancreatic SPT, with the characteristic solid and cystic components and areas of intratumoral hemorrhage. All the resection margins were free, although foci were found of perineural invasion, but not vascular. In the surgical specimen, 11 lymph nodes were isolated, none of which showed evidence of malignancy. The immunohistochemistry study was positive for alpha-1 antitrypsin, beta-catenin, vimentin and CD56, as well as weakly and focally positive for synaptophysin. These findings also favored the diagnosis of pancreatic SPT.

The most important retrospective SPT series was published by Papavramidis,⁵ who reviewed 718 cases reported in the English literature in 210 articles published by American, European and Japanese groups between 1933 and 2003. All the series reported the predominance of females, with a male:female ratio of 1:9.78. Mean age at presentation was 21.97

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