



**Figure 2** Resection specimen showing the presence of the ectopic pancreatic tissue in contact with the bowel lumen.

Another retrospective study reported 3 cases of ectopic pancreas causing bleeding in the small bowel among 76 cases of obscure gastrointestinal bleeding.<sup>8</sup> These data reflect the low incidence of symptoms in this relative rare entity. Nevertheless this type of lesions should be suspected when evaluating an obscure gastrointestinal bleeding, although it requires a high index of suspicion. Hyperamylasemia has been described in complicated ectopic pancreas but neither of them in a case of bleeding. This is the first report describing this relationship. Probably if diagnostic techniques continue to improve we can expect an increase in the incidence of these disorders.

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## Chronic abdominal pain originating in the abdominal wall<sup>☆</sup>



### Dolor abdominal crónico originado en la pared abdominal

Abdominal wall pain is an under-diagnosed cause of chronic abdominal pain. Since abdominal wall pain is not usually suspected as the origin of chronic abdominal pain by doctors, patients usually undergo extensive diagnostic testing and different treatments, and are often classified as having a functional or non-specific pain syndrome before the right

diagnosis is finally reached, sometimes years after the onset of symptoms.<sup>1</sup>

A 34-year-old male patient was referred to the digestive health clinic after suffering from fluctuating, but daily, abdominal pain in his left side for 3 months. This pain was interfering with his usual activities, improved when lying down and got worse with hyperextension and flexion of the trunk. He complained of suffering from dyspepsia with slow digestion and reflux symptoms for several years that had not got any worse recently. He had not experienced any changes in bowel habits or weight loss. Upon physical examination, the patient complained of pain and tenderness on his left side, with a trigger point that reproduced pain and was accompanied by vagal reactions that worsened with extension of the abdominal musculature; no masses could be felt. The patient was assessed regularly over 4 months at the clinic with objective evidence of pain, resulting in the following tests being ordered: full blood count, faecal calprotectin, abdominal ultrasound, abdominal CT scan, endoscopy with rapid urease test and

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duodenal biopsies, ileocolonoscopy, MR enterography and soft tissue ultrasound. All results were normal, or showed insignificant alterations, that did not explain the patient's symptoms. The patient experienced no improvement after being treated with common analgesics, anti-inflammatory drugs, antispasmodic drugs or low-dose antidepressants. The patient was also assessed by general surgery which proposed performing an exploratory laparoscopy, although this offered little chance of finding a cause, and was assessed by the pain management unit, which initially ruled out any treatable disease. Given that the symptoms continued and that the doctors suspected abdominal wall pain, the patient was referred again to the pain management unit. The unit performed an initial infiltration of topical anaesthetic, which failed, followed by a second infiltration between the two abdominal obliques with complete remission of all symptoms. After being on this treatment for 6 months, the patient is still asymptomatic.

Abdominal pain is a common disorder, seen by both primary care and specialist doctors. It is estimated that 10 to 30% of patients with chronic abdominal pain of unknown cause actually have abdominal wall pain, although it is still currently an under-diagnosed disorder due to low clinical suspicion.<sup>2</sup> Before diagnosis, patients have usually already undergone numerous diagnostic examinations and failed treatment attempts, and have been classified as having a functional or non-specific pain syndrome.<sup>1</sup>

Abdominal wall pain is pain originating in the anatomical structures of the abdominal wall (skin, subcutaneous tissue, peritoneum, muscles, nerve endings) and is more common in women aged 30–50 years. The most common cause is abdominal wall hernias, while other causes include cutaneous nerve entrapment, surgical scarring, haematomas, endometriosis, Herpes zoster, abdominal pain referred from thoracic nerve endings or obesity due to an increase in intra-abdominal pressure.<sup>3</sup>

Diagnosis is based on the patient's medical history and abdominal examination.<sup>4</sup> Pain is chronic and suffered every day; it is usually localised to a single point and is not associated with other accompanying digestive symptoms. Carnett's sign can be used to diagnose this entity.<sup>5</sup> It is performed with the patient lying face up; the doctor presses on the tender point while the patient lifts his/her head and trunk to contract the abdominal muscles. If the pain increases or remains unchanged (positive Carnett's sign), it is considered to originate from the abdominal wall. However, if it decreases (negative Carnett's sign), the cause is visceral since the tensed muscles protect the viscera.<sup>6</sup>

When the pain is tolerable and the patient's quality of life does not deteriorate, the use of local measures and postural education may be sufficient. The effectiveness of analgesics and antidepressants is limited. When the pain is more severe, local injection of topical anaesthetics into the tender area is effective, and also helps confirm the diagnosis.<sup>7</sup> Corticosteroids may be used concomitantly to prolong the effect and several sessions are sometimes required because recurrence of symptoms is common. In exceptional cases, surgery may be required to release trapped nerves or remove wall lesions.<sup>8</sup>

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