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Hyperamylasaemia and gastrointestinal bleeding as the first manifestation of jejunal ectopic pancreas

Hiperamilasemia y hemorragia digestiva como primera manifestación de páncreas ectópico yeyunal

The presence of ectopic pancreatic tissue is a relatively rare entity. Just a few retrospective case series are available in the literature. It is usually an incidental finding without clinical consequences. Between those patients who develop symptoms, bleeding has been described as a rare complication of this condition. We describe a case report of gastrointestinal bleeding and hyperamylasemia secondary to jejunal pancreatic tissue successfully managed with surgery.

A 31 year-old woman was admitted to our hospital because of gastrointestinal bleeding. She had no relevant past personal or family medical history. She was only taking folic acid because she was planning to become pregnant. She had been also taking nonsteroidal anti-inflammatory drugs during the last month. In the previous week before admission she had observed daily melenic stools. She also complained of mild to moderate colicky abdominal pain. Physical examination was unremarkable. Blood analysis revealed iron deficiency anemia (hemoglobin 7.3 g/dL, ferritin <3 ng/ml, transferrin saturation 3.1%) and mild hyperamylasemia (pancreatic amylase 128 U/L, normal range 13–53). An urgent upper endoscopy showed no signs of gastrointestinal bleeding. A computed tomography was performed and showed a mass in proximal jejunum of 22 mm. This lesion showed a morphology and tissue enhancement similar to those in the pancreas, so an ectopic pancreatic tissue was suspected. Capsule endoscopy revealed a submucosal mass located in the jejunum, without active bleeding. This finding was further confirmed by magnetic resonance enterography (Fig. 1). A laparoscopic segmental resection was performed during the admission. The final histological diagnosis revealed a jejunal ectopic pancreatic tissue of 27 mm with superficial ulceration (Fig. 2).

An ectopic pancreas is defined as pancreatic tissues lacking vascular or anatomic communication with the normal body of the pancreas, yet possessing histological features of pancreatic acinar formation, duct development and islets of Langerhans with independent blood supply and ductal system.[1–3] It is supposed to arise due to the persistence of a duodenal evagination involved in the normal development of the pancreas. Another hypothesis suggests the presence of pancreatic metaplasia of the endodermal tissue in the gastric mucosa.[4] It has been described in multiple locations along the gastrointestinal tract, being the stomach the most common (25–38%).[4] There are also cases in the duodenum (9–36%) and jejunum (0.5–27%), as well as other extraintestinal locations. It often arises in within the submucosa (75%) but sporadically also in the muscularis propria and serosa.[5] Heinrich described four types of pancreatic heterotopia initially in 1909. In 1973 Gaspar–Fuentes included some modifications to this classification.[6] This classification is based upon the structures observed in the ectopic tissue (pancreatic ducts, acinar tissue and islet cells).

In previous case series only 73 out of 212 patients with ectopic pancreatic tissue were symptomatic. Bleeding from an ectopic pancreas was observed only in 3 of them.[7]

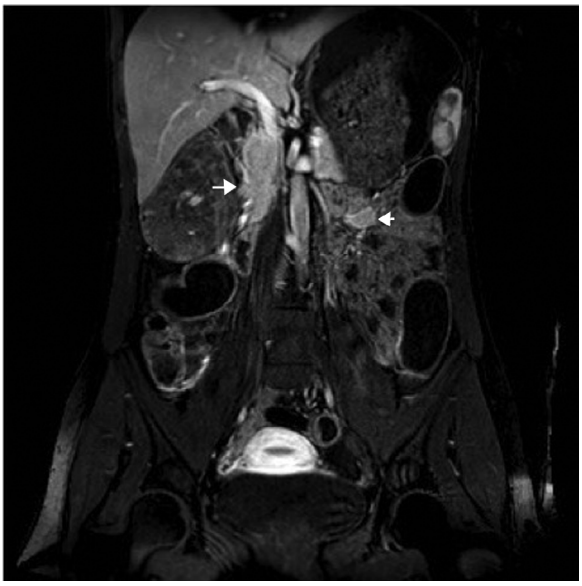

Figure 1 Magnetic resonance enterography (T1) showing a mass in the jejunum (arrowhead) suggestive of ectopic pancreatic tissue. Normal pancreatic tissue is also present (arrow).

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.[8] 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☆

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.[1]

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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