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A Case of Gastric Aberrant Pancreas

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Abstract **Case Report**

Aberrant pancreas is defined as pancreatic tissue that has neither anatomic nor vascular continuity with the normally located pancreas [2]. Aberrant pancreas is frequently asymptomatic but may cause intussusception or complications from inflammation. In this work, we will present a case of a patient who presents epigastralgia and upper endoscopy has objectified an aberrant pancreas. The patient underwent surgery which confirmed the diagnosis.

Keywords: Aberrant pancreas, pancreatic tissue, epigastralgia, endoscopy.

INTRODUCTION

The pancreatic tissue existing in an organ or tissue distinct from the pancreas has been called aberrant pancreas (AP), heterotopic pancreas (HP), pancreatic rest, or accessory pancreas [1]. Aberrant pancreas is defined as pancreatic tissue that has neither anatomic nor vascular continuity with the normally located pancreas [2]. Aberrant pancreas is frequently asymptomatic but may cause intussusception or complications from inflammation [3]. AP may be seen in the stomach during upper gastrointestinal (GI) endoscopy when it can be confused with other pathologies. Gastric HP typically appears as a single wellcircumscribed broad based submucosal nodule in the gastric antrum, more often on the greater curve, and frequently surmounted by a dimple or pit representing the drainage orifice of the ectopic pancreatic tissue [4].

CASE PRESENTATION

In this work we present a case of a 65-year-old woman with no known pathological history, who presents with chronic epigastric pain, an abdominal scan was performed showing circumferential thickening of the gastric wall. upper endoscopy showed a lesion in the gastric antrum corresponding to an aberrant pancreas (Figure 1).

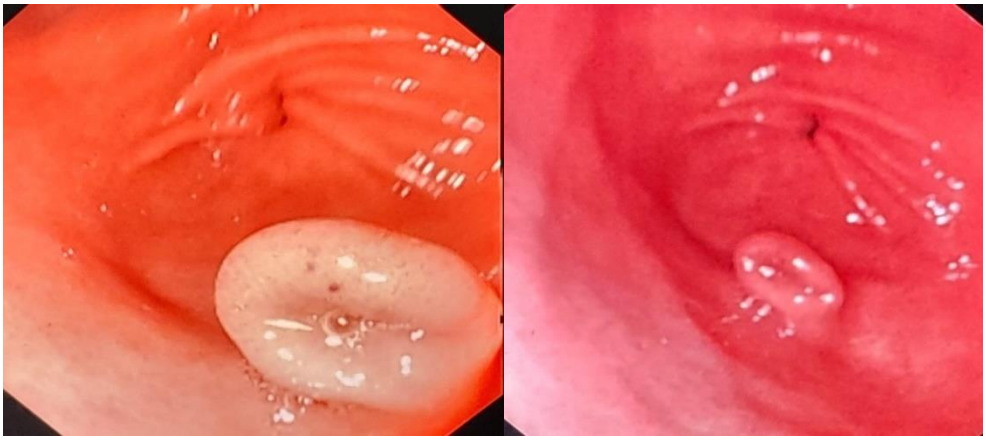

Figure 1: Gastric aberrant pancreas

The surgical intervention was suggested so she was admitted. Physical examination was unremarkable. Her routine blood examinations were normal, including white blood cells, hemoglobin, platelet, renal function, liver function tests and tumor markers. Wedge resection of gastric tumor plus pyloroplasty was performed uneventfully. The pathology of resected gastric lesion showed heterotopic pancreas.

DISCUSSION

Because patients with aberrant pancreas are usually asymptomatic, the lesion is found incidentally during clinical investigation for other gastroduodenal diseases [5]. Aberrant pancreas sometimes causes symptoms associated with pancreatitis, cyst formation, ulceration, bleeding, obstructive jaundice, and gastric outlet obstruction [6]. The overall frequency of the heterotopic pancreas was reported to be 0.6- 13.7% of autopsies [5] and the rate for this lesion in the stomach might be much less than that. In one study, 8,154 gastric specimens (from biopsies or gastrectomy) were reviewed, and only three cases were (0.04%) found to have the heterotopic pancreas [6]. If symptoms or signs develop, the most frequent presentations may be abdominal pain, and/or abdominal fullness, and tarry stools [7]. The result of routine endoscopic biopsy may also be inconclusive [8]. One study developed specific criteria based on computed tomographic findings to differentiate gastric/duodenal heterotopic pancreas from small GIST or leiomyoma [9]. Another study found that magnetic resonance imaging (MRI) with diffusionweighted imaging (DWI) may help in differentiating ectopic pancreases from upper gastrointestinal subepithelial tumors [10]. There is currently an ongoing academic debate as to whether an ectopic pancreas should be excised. Supporters advocate the removal of this lesion as early as possible as a means of prophylaxis due to the fact that it can be a predisposing factor for all typical pancreatic disorders, from acute and chronic pancreatitis to neoplastic transformation [11, 12]. EUS-FNA is useful for making an accurate histological diagnosis of the lesion, although its value requires further assessment and future improvements. In addition, an ESD-based method, such as that mentioned in the study by Kobara *et al*., [13], can overcome the flaw of no adequate tissue samples being obtained from conventional biopsy and EUS-FNA [14], and can deeply improve the accuracy of diagnosing this disorder prior to management. Laparoscopic endoscopic cooperative surgery— the utilization of intraoperative endoscopic localization— may be useful in selected cases to preserve cardia or pylorus [15]. Endoscopic mucosal resection and submucosal dissection have both been shown to be safe and effective treatment options in dealing with such lesions [16-19].

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