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Case Report
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An Aberrant Pancreas of the Gastric Antrum Mimicking an Ulcer

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Introduction

It is difficult to establish a formal diagnosis of a "cystic" mass of the digestive tract in preoperative. Symptoms may include haemorrhage, occlusion, cancer or digestive ulcer. Indeed, the preoperative exams allow describing the morphology of the lesion without being able to establish a certainty diagnosis with sometimes a non-contributory biopsy. We describe here a clinical case of aberrant pancreas mimicking a bulbar ulcer and then a review of the literature on aberrant pancreas.

Clinical Case

This is a 44-year-old patient with no prior history or treatment, diagnosed 4 years ago with an ulcer of the first perforated duodenum as a result of epigastric pain and NSAID use. This ulcer had been treated by laparoscopic drainage in another center. The control fibro copy did not find any anomaly.

After a recurrence of these pains, he was given a scanner that finds an antral collection with a bubble of air in the collection (Figure 1). She had a fibroscopy 48 hrs after the onset of pain that did not recover any abnormality and biopsies showing a gastric mucosa without abnormality.

The patient's file had been discussed in a medical-surgical meeting; it had been decided to perform an echo-endoscopy. Two months later, the echo-endoscopy was on standby and the patient presented to the emergency room for epigastric pain with right hypochondrium irradiation. Clinically, the patient presents an epigastric defense with a mass perceived on palpation.

There is no abnormality in the biological assessment.

A new CT scan is performed, with a marked increase in the lesion with multiple intra centimeter ganglionic formation (Figure 2).

We perform an endoscopic echo which finds: 3 sub centimeter peripheral adenopathies in the antral region, a pre -pyloric arch with a whitish discharge. In ultrasound, this heterogeneous mass is seen with a hypo-echogenic zone in depth evoking to the endoscopist not a tumor process but a pseudo-cystic form in the process of fistulization of cystic dystrophy type on aberrant pancreas, no puncture possible.

The tumor markers (ACE and Ca 19-9) are normal; there is no inflammatory syndrome, no deglobulation.

In view of the symptomatology and the uncertainty of the diagnosis, it is decided to perform

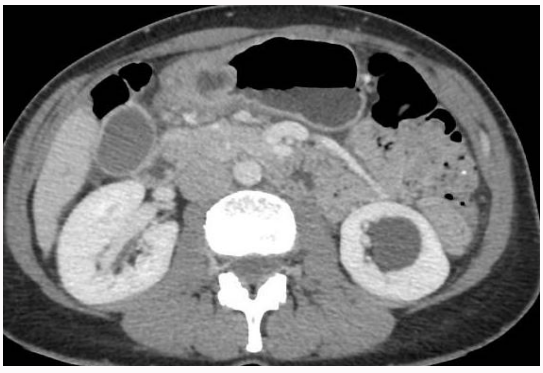

Figure 1: Initial scanner (lesion identified by the arrow).

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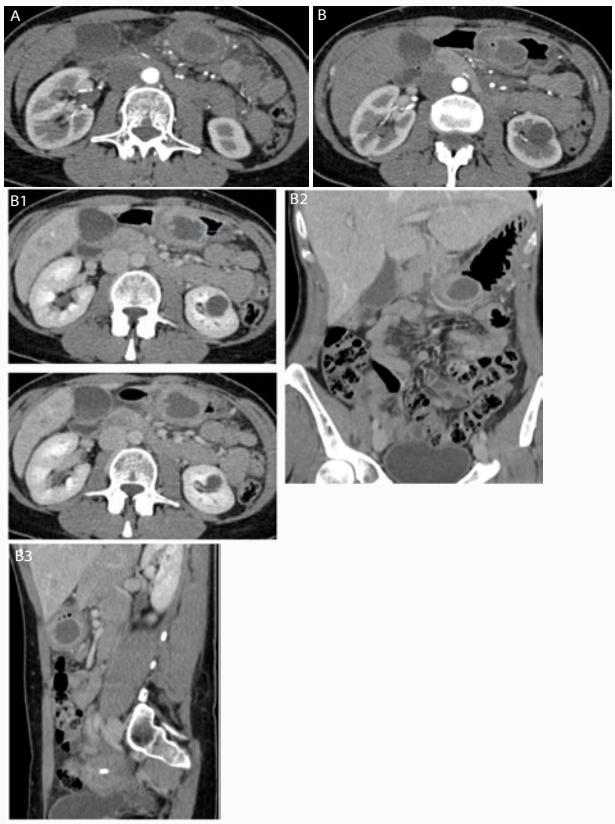

Figure 2: Lesion 2 months later. **A**: Arterial time, **B**: Portal time. **B1**: Axial cut, **B2**: Coronal cut, **B3**: Sagittal cut.

an excision of the mass. We performed laparoscopic anteromy with a gastroduodenal anastomosis by a short median laparotomy. The patient was able to leave the service 15 days after the intervention after drainage mobilization and gradual replenishment.

The anatomopathological results show: a lesion of 3.5 cm × 3 cm × 1.8 cm. It is a lesion of firm consistency, of heterogeneous appearance bulging under the mucous membrane but without ulceration. The lesion is made up of different components of normal pancreatic tissue. The epithelium is well labeled with the anti-cytokeratin 7 antibody. Quite a few elements are labeled with the anti-CDX2 antibody. The reaction is negative with the anti-Cytokeratin 20 antibody. This formation is remodeled by purulent necrotic-haemorrhagic and also inflammatory phenomena producing a central cavity. The gastric mucosa opposite is not ulcerated. The conclusion is therefore that of an aberrant pancreas.

Discussion

The diagnosis of aberrant pancreas is a rare diagnosis which is often referred to in anatomo-pathology after intervention for a cystic mass developed within the digestive tract. Preoperative diagnosis is difficult because the biopsy is often difficult and/or non-contributory. Imaging, on the other hand, evokes a cystic mass without being able to assert a diagnosis.

In the literature, via a PubMed search with the keywords "aberrant pancreas", there are many articles. More than 285 clinical cases have been published. The majority of the cases concern gastric and intestinal localizations and especially in children. Nevertheless, there are described cases of the entire digestive tract and the bile ducts (small intestine, colon, gallbladder, duodenum ...).

As far as the gastroduodenal localizations as for our case, we find in the literatures of multiple symptoms.

The first cases described date from 1946 [1] with symptom descriptions varying between abdominal pain [2-4], upper or lower digestive hemorrhage [5-10] , Acute [11-15] or chronic pancreatitis [16], ulcers [17-20], occlusions [21] and stenosis of the pylorus [22] in children or more Rarely a cancerous form [23,24]. It is a congenital lesion found in 0.55 to 14% of the autopsy series [25]. Often, this is a fortuitous discovery on the basis of an examination carried out for another reason. Endoscopic and/or radiologic descriptions were obtained in a case of gastroduodenal localization, a rather antropyloric position [26,27] in 88% of the cases in an article describing 65 cases out of 9650 gastric resections. The multiple imaging examinations describe a difficult diagnosis [26,28,29] with a heterogeneous lesion on ultrasound or echo-endoscopy [16,22,25,30]. This mass is developed in the submucosa, most often between the submucosa and the clean muscle [16,24-27,31] with a variable size of 0.5 cm to 5 cm most often.

Because of the symptomatology, the authors agree on the indication to a resection most often [24]. This resection can be performed by endoscopy [2,32,33] or by surgery [3,11,34] or by combined surgical and endoscopic technique at the same time [8].

Conclusion

The aberrant pancreas is a rare lesion of difficult diagnosis capable of mimicking many symptoms. The diagnosis is often asserted after resection on the final pathologic examination. When symptomatic, surgical and/or endoscopic resection is indicated.

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