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Dynamic Contrast-Enhanced MRI Findings of Acute Pancreatitis in Ectopic Pancreatic Tissue: Case Report and Review of the Literature

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ABSTRACT

Context Acute pancreatitis in ectopic pancreatic tissue is an uncommon cause of acute abdominal pain and can be difficult to diagnose on imaging. Our aim is to raise awareness and aid in the diagnosis of this entity by highlighting helpful dynamic contrast-enhanced MRI imaging findings. Case report We report a 51-year-old man with acute onset epigastric pain presented to ER. With the presence of elevated serum lipase, the clinical diagnosis of acute pancreatitis was made. Contrast enhanced CT demonstrated normal pancreas and a focal mass at the duodenojejunal flexure, mimicked a neoplasm. Subsequent dynamic contrast enhanced MR images demonstrated enhancement pattern of the lesion similar to the native pancreatic tissue enhancement, a finding raised the possibility of acute pancreatitis in ectopic pancreatic tissue, but tumor was not excluded. Finally, patient undergone surgical bowel resection including the suspected mass that was proved as an ectopic pancreatic tissue on microscopic examination. Conclusion We concluded that findings on dynamic contrast enhanced MR imaging can be characteristic and diagnostic of acute pancreatitis in ectopic pancreatic tissue in the appropriate clinical setting.

INTRODUCTION

Acute pancreatitis is the most common gastro-intestinal causes of acute hospitalization in the United States [1]. Acute pancreatitis is a clinical diagnosis, usually made on history, physical exam findings and correlation with biochemical markers such as elevated amylase and lipase [2].

Even in the setting of elevated serum pancreatic enzymes and clinical findings of acute pancreatitis, the pancreas may appear normal in CT imaging in very early, non necrotizing pancreatitis i.e. Balthazar grade A acute pancreatitis [3]. The sensitivity of CT and MRI in detection of severe acute pancreatitis is 78% and 91% respectively [4, 5]. In such a situation, it is also important to consider the possibility of acute pancreatitis in ectopic pancreatic tissue since the incidence ectopic pancreas is up to 14% at autopsy [6]. Awareness of this entity and knowledge of pertinent imaging findings will aid in detecting this uncommon diagnosis and differentiating it from other mimickers such as submucosal tumors. Thereby, an appropriate initial conservative management can be performed without misdirection towards surgery or biopsy.

At our institution, encountered a case of acute pancreatitis in ectopic pancreas located in the jejunum with imaging features identical to a submucosal tumor. Here, we have described our case, reviewed relevant literature, and discussed the radiologic findings which are helpful to diagnose this condition.

CASE REPORT

A 51-year-old male presented in the emergency department with acute onset of epigastric pain, radiating to both flanks. Past medical history was significant for hypertension, hypercholesterolemia, hypertriglyceridemia, and coronary artery disease status post stent placement. Social history was significant for tobacco use and alcohol abuse. On physical examination, the abdomen was distended eliciting mild diffuse tenderness. Serum lipase was elevated at 177 U/L (reference range: 0-50 U/L), rise in serum aspartate transaminase at 123 U/L (reference range: 10-40 U/L) and rise in serum alanine transaminase at 196 U/L (reference range: 10-40 U/L). The clinical diagnosis of acute pancreatitis was made and decided to perform CT study.

In the ER, CT examination was performed on a 256-slice dual source scanner (SOMATOM Definition Flash, Siemens Medical Solution). Contrast-enhanced CT in venous phase (80 sec delay) was done after intravenous administration of 80 cc of Omnipaque 300 (iohexol with iodine content of 300 mg/mL). The datasets were reconstructed with slice-thickness of 5 mm in axial, coronal and sagittal planes. The images demonstrated a focal mass measuring 2.5 x 2.8 cm, located at the duodenojejunal flexure and separate from normal appearing pancreatic body (Figure 1a-c). Additionally, there was focal, moderate jejunal wall thickening and adjacent mesenteric fat stranding. The constellation of these findings suggested a submucosal tumor or jejunal diverticulitis.

With the given atypical findings, it was decided to perform MRI study with MRCP sequences. On the next day after CT, the MR examination was done on a 1.5T system
edema, and granularity of the mucosa at duodenojejunal flexure along with finding suggestive of extra luminal process. Nearly 2 months after the initial ER admission, the patient had undergone surgical wedge resection of the jejunal mass. Gross examination of operative specimen showed 3.0 x 2.2 x 1.0 cm soft tissue fragment between serosa and mucosa on either side. The cut surface of the mass was lobulated tan/yellow tissue within the muscularis propria and submucosa.

DISCUSSION

Ectopic pancreatic tissue is defined as presence of pancreas tissue outside the anatomic location of the pancreas without any anatomic continuity or vascular connection [7]. This pancreatic tissue has its duct which drains into the adjacent bowel. The incidence ectopic pancreas varies from 0.55% to 14% at autopsy [6]. The most common location of ectopic pancreatic tissue is around the pancreas (86%) like duodenum, stomach especially prepyloric antrum, and proximal jejunum [8]. It can also be seen in the ileum and Meckel's diverticulum.

Individuals with ectopic pancreatic tissue are usually asymptomatic and it is discovered incidentally at surgery or autopsy. When symptomatic, patients tend to experience symptoms in the 4-6th decades [9]. The most common symptoms are abdominal pain, GI bleeding, and
obstruction. However, this tissue can also present with any complications occurring in the native pancreatic tissue, such as pancreatitis, as seen in our case. The reported complications are acute pancreatitis, pseudocyst, benign and malignant neoplasm [10-12].

Imaging findings may be confusing or misleading related to the presence of secondary changes from acute or chronic pancreatitis, as in our case, where the morphology most closely resembled a submucosal tumor. Ectopic pancreatic tissue has been well described in the literature on barium examinations as a smooth, elevated mucosal/sub mucosal lesion with central umblication. There can be central linear barium filling the duct, which opens into the bowel lumen [8, 13].

Both CT and MRI are good imaging modalities especially with the high index of suspicion in a patient presenting with acute abdominal pain and biochemical evidence of elevated pancreatic enzyme. Most often and in acute ED settings, CT will be the first imaging modality to evaluate this entity. The contrast enhancement of ectopic pancreatic tissue is dependent on the predominance of pancreatic acini which tends to enhance well and similar to normal pancreas. On
Ectopic pancreas presenting as acute pancreatitis is an unusual, but an existing entity. Awareness and knowledge of expected findings are key factors in diagnosing this condition, especially in patients with a clinical diagnosis of acute pancreatitis and normal appearing pancreas on cross sectional imaging. CT and MRI plays significant role in diagnosis of this entity. Findings on dynamic contrast enhanced MR imaging, with the aid of MRCP sequences, can be characteristic and diagnostic in the appropriate clinical setting.

REFERENCES