SUCCESSFUL USE OF MINOR PAPILLOTOMY IN PANCREAS DIVISUM WITH WALLED-OFF NECROSIS: READY FOR PRIME TIME?

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INTRODUCTION

- Despite the relative rarity of congenital anomalies of the pancreas, they can result in some clinical symptoms, such as recurrent abdominal pain, recurrent acute pancreatitis (RAP), or chronic pancreatitis.
- Nearly 8-10% of the population experience pancreatic congenital anomalies. The most common is the pancreas divisum (PD).
- To successfully treat a symptomatic PD, minor papillotomy (MiP) is the mainstay of endoscopic therapy, especially when access is difficult via the major papilla.
- Here we present a case of PD complicated with necrotizing pancreatitis successfully treated with MiP and pancreatic stenting.

DISCUSSION

- MiP is the cornerstone of endoscopic therapy for symptomatic PD (RAP, chronic pancreatitis, or chronic abdominal pain).
- MiP as an adjunct treatment for walled-off necrosis (WON) has been described in the few studies that assessed endoscopic therapy for symptomatic PD.
- MiP and endoscopic therapy use in PD with WON might benefit this subset of patients, but that requires further investigation.

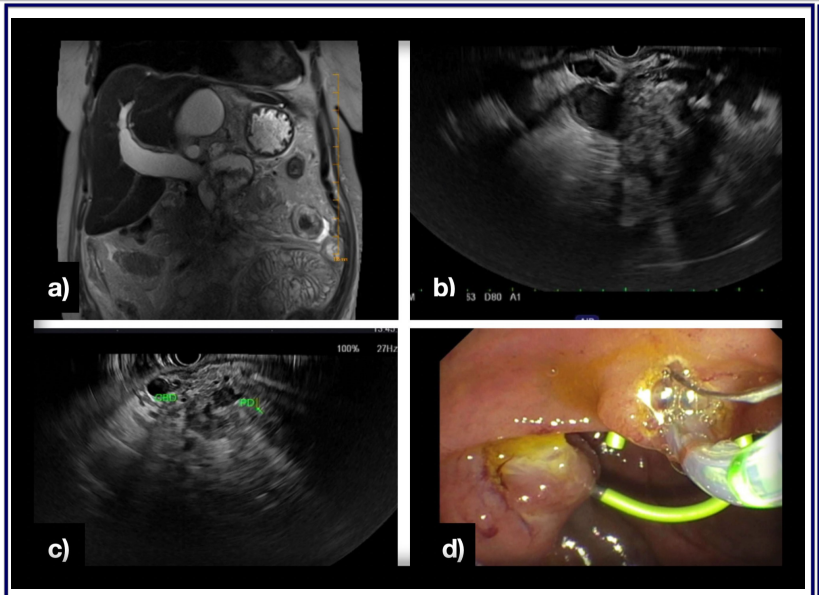

FIGURE:

a) Magnetic resonance T2-coronal image showing walled-off necrosis (WON) invading a thrombosed portal vein and a pseudocyst between the liver and stomach.
b) Endosonography image showing the walled-off necrosis (WON) invading the portal vein.
c) Incomplete divisum with the pancreatic duct coursing across the bile duct toward the minor papilla on EUS.
d) Endoscopic treatment with major papillotomy (below) is done, and minor papillotomy MiP (above) is undertaken with a pull-type sphincterotome.

CASE DESCRIPTION

- A 56-year-old female with prior history of RAP presented with intermittent epigastric pain, nausea, and vomiting for 1 month. A physical exam showed stable vital signs and mild epigastric tenderness. Laboratory work showed mild elevation of WBC and serum lipase 5 x of ULN.
- MRI showed multiple pancreatic fluid collections (Img a) and evidence of incomplete PD. Endosonography showed a large pseudocyst between the liver and stomach and WON around the pancreatic head, invading a thrombosed main PV (Img b). EUS confirmed incomplete PD (Img c). Transluminal drainage of the WON was not attempted because of the PV invasion. ERCP was successfully performed, with major & minor pancreatic papillotomy & plastic stenting (Img d). Biliary cannulation showed a dilated bile duct but was otherwise unremarkable.
- The patient was continued on supportive therapy and later required percutaneous drainage of the pseudocyst between the liver and stomach.
- A subsequent MRI showed significant WON resolution 3 months later, and the patient was convalescing well.

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