

Endoscopic Ultrasound (EUS)/Elastography

Patient History

A 59-year-old male was referred for persistent epigastric pain status post hospitalization for idiopathic acute pancreatitis three months prior. Outpatient workup revealed persistently elevated serum amylase and lipase levels since the time of discharge as well as a Computer Tomography (CT) showing peri-pancreatic inflammatory changes with a dilated pancreatic duct (PD) (Figure 1). Careful review of the CT showed a distinct caliber change of the PD in the body of the pancreas without obvious mass effect. The patient was scheduled for an outpatient endoscopic ultrasound for further evaluation.

EUS/Elastography Procedure and Findings

The PENTAX Medical EG-3870UTK linear endoscope was passed in standard fashion to the gastroesophageal junction where the celiac artery was followed to the body of the pancreas. The genu, body, and tail of the pancreas were well visualized and appeared diffusely hypoechoic (Figure 2a). A distinct caliber change of the pancreatic duct was noted at the level of the genu/proximal body. A definite mass in this

area, however, could not be identified due to the diffuse hypoechoogenicity of the gland (Figure 2b). Elastography was then applied and immediately revealed a 1.7 cm firm mass depicted in blue (Figure 3). EUS-guided fine needle aspiration of this mass revealed highly atypical cells suspicious of a pancreatic neoplasm (Figure 4).

Patient Follow-up and Outcome

The patient underwent an elective laparoscopic hand-assisted distal pancreatectomy and splenectomy. Review of the pathologic specimen revealed a moderately differentiated 1.7 cm adenocarcinoma with 0/25 lymph nodes involved (T1N0) in the setting of chronic pancreatitis. The patient had an uneventful hospital course and was discharged on post-operative day five. On last follow-up, patient is eating and gaining weight. Pain is resolved.

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Figure 1



Figure 2a



Figure 2b

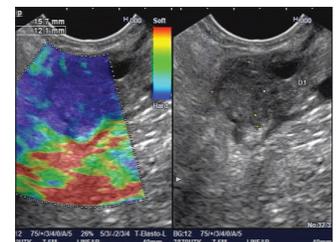


Figure 3



Figure 4

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