In The Groove: A Case Series of Groove Pancreatitis

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• Paradoxical wall cyst, and myoadenomatosis. Space bounded by the second portion of the duodenum laterally, literature as paraduodenal pancreatitis, pancreatic hamartoma or inferior vena cava posteriorly.

• Gastric antrum anteriorly, and the third portion of the duodenum

• Inflammatory cells. But typically with more pronounced post-prandial nausea and vomiting and weight loss.

• Esophagogastrduodenoscopy (EGD) and endoscopic retrograde cholangiopancreatography (ERCP) can be helpful to rule out other etiologies. Biopsy often required and should demonstrate chronic duodenitis and evidence of obstruction due to duodenal stenosis.

• CD scan revealed stenosis of the second portion of the duodenum and a hypodense mass within a thickened duodenum (Image 1).

Case 2: A 56 year-old male former smoker with an extensive past medical history involving severe vascular disease status post amputations underwent EUS/EUS-FNA to evaluate the pancreatic mass. This revealed a significant duodenal wall thickening with an edematous villose-like appearance of the second portion of the duodenum and an ampullary mass could not be ruled out. FNA was negative for malignancy and duodenal biopsy demonstrated chronic duodenitis. Two years later he presented with generalized weakness and melena. A CT scan revealed prominence of the pancreatic head and a hypodense mass within a thickened duodenum (Image 4). GGO and concern for malignancy lead to pancreaticoduodenectomy. Pathology revealed extensive scarring of the pancreatic head and duodenal musculature with numerous cysts, some of which were lined with densely infiltrated granulation tissue surrounded by scar. These findings are consistent with groove pancreatitis and supported duodenal resection as a possible contributor to the process.

- The true incidence of groove pancreatitis remains poorly known.
- This creates a diagnostic challenge due to the normal pancreatic tissue present in the groove and clinical presentation, and clinical practice guidelines recommend one of the grooves can make it “impossible” to differentiate from pancreatic adenocarcinoma. Especially in the segmental form which can involve the pancreatic head. Cases of concomitant groove pancreatitis and pancreatic adenocarcinoma as well as “pancreatic groove carcinomas” have also been described which leads to further complicating factors.

- Our patients demonstrate several classic risk factors and clinical findings of groove pancreatitis including male sex, current or former alcohol and/or tobacco abuse, duodenal stenosis leading to GOO and weight loss, Brunner gland hyperplasia, tubular CBD stenosis, normal CA 19-9 level, and atypical inflammatory cells on FNA. In comparison, pancreatic adenocarcinoma will commonly have findings of an abnormal pancreatic duct, peripancreatic vascular invasion, and obstructive jaundice, all of which are less often seen in groove pancreatitis.

- A prolonged course to diagnosis is also quite classic for groove pancreatitis. This is largely due to a lack of pre-operative diagnoses due to the inability to rule out malignancy.

- It has been reported separately in the literature that 50% of patients with chronic pancreatitis will undergo surgical treatment and that 24.5% of patients receiving pancreaticoduodenectomy for chronic pancreatitis have groove pancreatitis. Extrapolating this data would correlate with recent literature which suggests that groove pancreatitis is actually a very common form of chronic pancreatitis.

- We also highlight a patient successfully treated without surgical removal of the affected tissue. Instead, a gastrojejunostomy was created to bypass the GOO caused by the inflammatory mass. To date, he remains without endocrine or exocrine symptoms suggestive of the current literature, management of groove pancreatitis in this manner has not previously been described.

References:


