

A penetrating foreign body mimicking pancreatic cancer (with videos)

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A 73-year-old male was referred to our hospital for cramping and upper abdomen pain associated with fever. Moreover, the patient reported unintended weight loss (of approximately 8 kg) over the past 6 weeks. The increase in transaminase levels and the mild increase in reactive C-protein were documented in addition to the cholestasis test results (2- and 4-fold upper normal values, respectively). Neoplastic markers (Ca 19.9 and CEA) were normal.

Contrast-enhanced computed tomography showed an irregular low-density 40 mm mass in the body of the pancreas that extended to involve the proximal tract of the portal vein with lumen obliteration. No upstream dilation of the main pancreatic duct was documented, whereas peripancreatic lymph node involvement was described [Figure 1a]. Subsequent magnetic resonance confirmed the suspicion of a pancreatic neoplasia that measured approximately 25 mm and was associated with portal thrombosis.

A poorly defined hypoechoic area between the head and neck of the pancreas, with the presence of a linear

hyperechoic 60 mm image extending from the gastric wall to the portal vein, passing through the pancreatic gland was observed on EUS [Figure 1b; Video 1]. A penetrant foreign body (FB) emerging at the gastric antrum was confirmed on a subsequent upper gastrointestinal endoscopy [Figure 1c and 1d]. After a multidisciplinary discussion, we decided to remove the FB endoscopically. A 6 cm toothpick was carefully pulled out by forceps without complications [Video 2]. Moreover, anticoagulants were administered for 4 weeks to manage portal vein thrombosis. The pancreas and main pancreatic duct appeared normal on a subsequent abdominal ultrasound.

Most ingested FBs are naturally excreted and only 1% can cause perforation, but the risk of perforation increases up to 35% if a sharp object is injected. Pancreatic involvement is very rare. Published cases have always reported that fish bones penetrate through the gastric or duodenal wall and migrate into the pancreatic head or body. Accidental ingestion and

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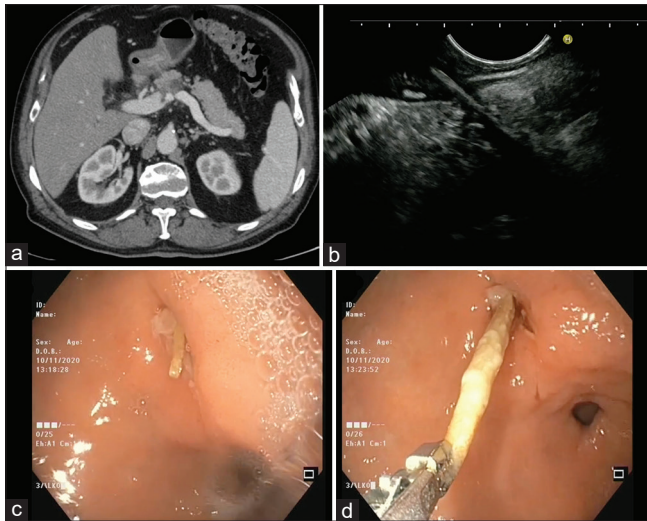


Figure 1. (a) Venous phase of computed tomography scan with evidence of a pancreatic hypovascular mass with portal vein lumen obliteration; (b) EUS detection of a linear hyperechoic image extending from gastric wall to the pancreatic neck; (c) endoscopic appearance of a sharp penetrating foreign body; (d) toothpick endoscopically removed by forceps

the presence of nonspecific symptoms are usually responsible for delayed diagnosis. Consequently, most cases require surgical intervention for a FB that is incapable of endoscopic removal and penetrates deeply into the gastric or duodenal or in cases with a pancreatic pseudotumor mimicking a neoplasm.^[1-4]

This is the first case of a wood-made FB that penetrates the pancreas, is diagnosed by EUS and then endoscopically removed. Some sharp FBs could be not visible on cross-sectional imaging, and EUS

could be useful in diagnosing this rare condition. In these patients, early diagnosis and prompt treatment are mandatory to improve prognosis and avoid surgery.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal his identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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