

An uncommon pancreatic mass lesion is leading to recurrent gastrointestinal bleed

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A 57-year-old male patient presented with a history of abdominal pain and melena, 4 times over past 2 months. He had severe abdominal pain radiating to back during these episodes and had melena each time, subsiding after few days. There was no history of abdominal trauma or liver disease. His outside gastroscopy was normal. In view of pain suggestive of pancreatic origin and history of melena, a diagnosis of hemosuccus pancreaticus was thought. His investigations revealed normal complete blood counts (history of blood transfusion outside for bleed), liver function tests and amylase. An ultrasound abdomen was done, it showed normal liver and there was no evidence of portal hypertension or splenic/portal vein thrombosis. A contrast-enhanced computed tomography (CT) abdomen were done, there was a suggestion of 1.2 cm × 1.0 cm hypodense lesion in body of pancreas causing dilatation of pancreatic duct distal to it and it was abutting the splenic artery with possibility of small aneurysm at this site [Figure 1]; possibility of a malignant lesion was kept. A side viewing endoscopy was done which showed blood coming out of papilla. An endoscopic ultrasound (EUS) was done, it showed a well-defined round lesion encasing splenic artery in relation to body of pancreas [Figure 2]. On the application of power Doppler, flow was seen in splenic artery [Figure 3]. There were subcentimetric lymph nodes in relation to

pancreas. The case was discussed with the radiologist; as CT findings were suggestive of malignancy, fine needle aspiration (FNA) from this lesion were taken. FNA revealed bloody aspirate only, there were no malignant or pancreatic cells. A repeat FNA was done with the same result, possibility of partial thrombosed aneurysm was kept. Abdominal angiography was done which confirmed presence of the aneurysm, it was embolized. A check angiogram after embolization of this aneurysm showed complete obliteration of it and the patient is asymptomatic at 12 months of follow-up. Hence a repeat angiography was not done (plan for repeat angiography in case of recurrence of bleed).

DISCUSSION

Based on EUS appearance of the lesion and it's relation to the splenic artery, possibility of thrombosed splenic

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Figure 1. CT image showing hypodense lesion in body of pancreas abutting splenic artery and causing pancreatic duct dilatation

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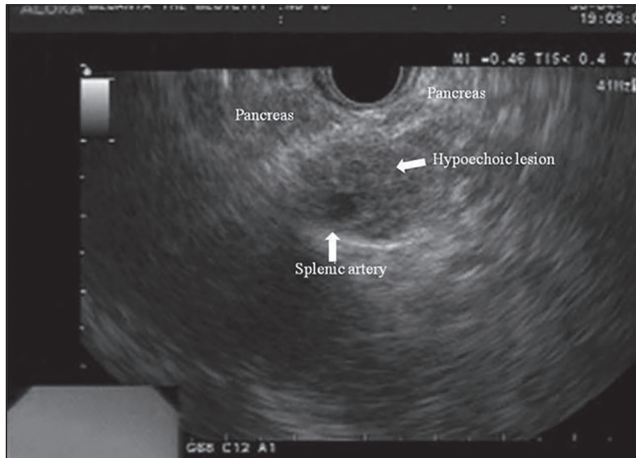


Figure 2. EUS image showing a hypochoic lesion in body of pancreas encasing splenic artery

artery aneurysm was kept. A conventional angiography was done which confirmed the presence of a small splenic artery aneurysm and it was embolized. The patient is asymptomatic in the follow-up. Visceral artery aneurysms are uncommon and pseudoaneurysms are rare. Splenic artery is the most common site of visceral artery aneurysms and pseudoaneurysms. Splenic artery aneurysms/pseudoaneurysms generally occur secondary to pancreatitis or trauma.^[1] Common presentations include gastrointestinal bleed, pain (abdominal/back or flank pain) and incidental detection on imaging. Hemorrhage from splenic artery pseudoaneurysm can manifest as bleeding into the peritoneal cavity, retroperitoneal space or pancreatic duct.^[1,2] A thrombosed aneurysm of splenic artery mimics pancreatic mass and may result in unwanted surgery.^[3] Thrombosed aneurysms may present as pancreatic tumors as they are not enhanced by contrast.^[4] Management options include observation, surgery or endovascular techniques (coil or glue). While rupture can lead to mortality, smaller aneurysms (<2 cm) grow slowly (0.2 mm/year) and carry a negligible risk of rupture.^[5]

The presence of a vascular lumen in the mass was suggestive of partial thrombosis of the aneurysm in this case. It is important to differentiate between

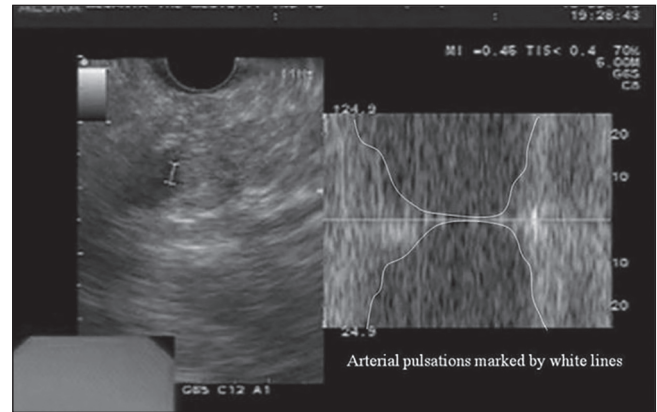


Figure 3. EUS image showing flow in splenic artery (arterial pulsations are marked by white lines)

pancreatic mass and thrombosed aneurysm to avoid unwanted surgeries. EUS provides better anatomic details of small pancreatic lesions than CT or magnetic resonance imaging (however, CT or magnetic resonance angiography are better for defining arterial anatomy and pathology). In the present case, EUS made a correct diagnosis and ruled out malignancy by negative FNAC, thus, an unnecessary surgery could be avoided.

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