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A Case of Ampullary Gangliocytic Paraganglioma

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Gangliocytic Paraganglioma (GP) is a rare benign peculiar tumor, mostly encountered in the periampullary area of the duodenum and in the jejunum or third part of the duodenum. Duodenal GP can present as an incidental endoscopic and radiologic finding or as gastrointestinal bleeding due to uleration of the overlying mucosa. A 41-year-old female patient presented with abdominal pain. Contrast enhanced computed tomography (CT) revealed a well-defined, enhancing, 2 cm oval shaped mass at the second portion of the duodenum, adjacent to the Ampulla of Vater (AOV). Endoscopic Ultrasonography (EUS) showed a hypoechoic mass confined to the submucosal layer. Deep subepithelial forcep biopsy was done after needle knife mucosal cutting. Histologically, a relatively well-demarcated lesion was noted in the submucosal layer of the duodenum and consisted of spindle cells, ganglion-like cells, and epithelioid cells. This case showed the characteristic histologic features of a tumor composed of 3 cell types, epithelioid, spindle, and ganglion cells, which is classified as a GP. Immunohistochemical stains for S-100 protein revealed strong positive reaction in the spindle cells. The epithelioid cells and ganglion-like cells expressed synaptophysin. The immunohistochemistry results confirmed the GP diagnosis. The tumor was resected via endoscopic mucosal resection (EMR).

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Diagnostic Role of EUS in Groove Pancreatitis

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Context: Groove pancreatitis is a rare form of chronic pancreatitis localized within the ‘groove’ between the pancreatic head, duodenum and common bile duct. **Case report:** A 56-year-old man was admitted to our hospital with epigastric pain and nausea. Enhanced abdominal computed tomography (CT) revealed swelling of the pancreatic head and focal wall edema of the second portion of the duodenum with a cystic lesion around the pancreaticoduodenal groove. Peripancreatic fluid collection was also seen. Upper gastrointestinal endoscopy revealed multiple ulcer scars with pseudodiverticulum and contracting folds at bulb and bulging contour at 2nd portion of duodenum. Endoscopic ultrasound (EUS) showed an anechoic round lesion interrupting 3rd, 4th and subserosa of the duodenal wall at level of uncinate process. These findings appeared consistent with the diagnosis of groove pancreatitis. The patient was treated with conservative medical management for 1week and symptoms subsided. Imaging problems described above completely disappeared on following abdominal CT after four months. **Conclusions:** Discrimination of groove pancreatitis from pancreatic head cancer can often be difficult and is confirmed by surgery such as pancreaticoduodenectomy. Therefore, imaging examinations is very important to diagnose groove pancreatitis. EUS is helpful modality to differentiate groove pancreatitis from pancreatic head cancer.