

A 42-year-old Filipino woman presented to casualty with a 3-hour history of worsening dull epigastric pain. She was afebrile and physical examination revealed localised rebound tenderness on the left side of her abdomen. Laboratory investigations showed a leukocytosis of $13.1 \times 10^9/L$ and a raised amylase level of 343 U/L.

An urgent multi-detector computed tomographic (CT) scan (Aquillon 16; Toshiba, Tokyo, Japan) of the abdomen and pelvis with intravenous contrast was performed for the evaluation of suspected peritonitis. The CT scan revealed a well-circumscribed enhancing lobulated mass in the mesentery of the proximal jejunum in the left upper abdomen, measuring about $2.6 \times 2.0 \times 4.5$ cm. The mass closely abutted the mesenteric border of the jejunal wall (Fig 1a) with a central ductal structure noted over the superior aspect of the mass (Fig 1b). Surrounding hypoattenuating fluid was noted in the mesentery. It was suspected that the mass was an ectopic pancreas based on the presence of a ductal structure. The main differential diagnoses considered were a possible ectopic pancreatitis and a small bowel tumour.

The patient was treated conservatively with antibiotics and her symptoms subsided within 3 days. An interval magnetic resonance imaging (MRI) study of the abdomen with magnetic resonance cholangiopancreatography (MRCP) was arranged for further characterisation of the suspected ectopic pancreas one and a half months later. We obtained HASTE (half-Fourier acquisition single-shot turbo spin-echo) T2 axial and coronal images for MRCP, fast low-angle shot (FLASH) T1 with in-and-out phases and short T1 (tau) inversion recovery (STIR) T2 images along with gadolinium-enhanced FLASH T1 axial images in arterial and portovenous phases using Siemens Symphony 1.5T MRI (Siemens, Erlangen, Germany). In all sequences, the mass showed signal intensities that paralleled the native pancreas. Magnetic resonance cholangiopancreatography confirmed the presence of a duct arising from the mass, coursing superiorly into the proximal jejunum (Fig 2). These findings are compatible with an ectopic pancreas.

Discussion

Ectopic pancreas has an estimated incidence of 0.55 to 14% according to autopsy series.¹ Although an ectopic pancreas seldom causes clinical symptoms, ectopic pancreatitis has been described in both adult and paediatric populations.² In the past, this diagnosis could only be made using invasive procedures and



FIG 1. (a) Post-contrast coronal multiplanar reformatted computed tomographic (CT) image showing an enhancing lobulated mass abutting the proximal jejunum with surrounding fluid. (b) Post-contrast axial CT image showing a ductal structure over the superior aspect of the mass



FIG 2. Magnetic resonance cholangiopancreatography confirming the presence of a duct arising from the mass

a histopathological analysis. Silva et al³ recently suggested that MRCP has a diagnostic role to play in detecting an ectopic pancreas by demonstrating an ectopic duct arising from a mesenteric or small bowel mass draining into the small bowel.³ The preoperative suggestion of acute ectopic pancreatitis may potentially spare patients from immediate surgery as uncomplicated ectopic pancreatitis can be treated conservatively. Magnetic resonance cholangiopancreatography may also have an added value in being able to assess any obstruction to the ectopic duct in the emergency setting.

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