

**Title:**

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***Hemosuccus pancreaticus* with a variant of separate orifices in the duodenal papilla treated with a covered self-expandable metal stent**

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**CASE REPORT**

A 94-year-old female was referred to the Emergency Department with melena. She had been diagnosed with pancreatic cancer one month previously (Fig. 1A, arrow) but refused further management. A side-viewing endoscopy showed two separate orifices of the duodenal papilla. There was fresh blood gushing out through the cranial orifice in the 1 o'clock position to the other caudal orifice in the 7 o'clock position (Fig. 1B, arrow head). Both orifices were selectively cannulated to demonstrate the common bile duct with a well-defined delineation through the orifice in the 7 o'clock position. The pancreatic duct was almost totally obstructed below the mid part of the pancreatic duct through the other orifice in the 1 o'clock position (arrow head) (Fig. 2). A fully covered self-expandable metal stent was inserted through the pancreatic duct of 8 mm in diameter and 60 mm in length (Tae Woong, Seoul, Korea) (arrow head), to treat the *hemosuccus pancreaticus* (Fig. 3). The patient recovered uneventfully and was discharged with no evidence of bleeding.

**DISCUSSION**

This is the peculiar case of endoscopic treatment with a metal stent in a patient with *hemosuccus pancreaticus* and pancreatic cancer, who refused surgical treatment due to old

age. Reports of endoscopic hemostasis in *hemosuccus pancreaticus* are very rare (1). Moreover, our case showed a variant location of separate orifices in the major duodenal papilla. This rare variant should be handled promptly as late recognition could result in unnecessary manipulation and treatment failure.

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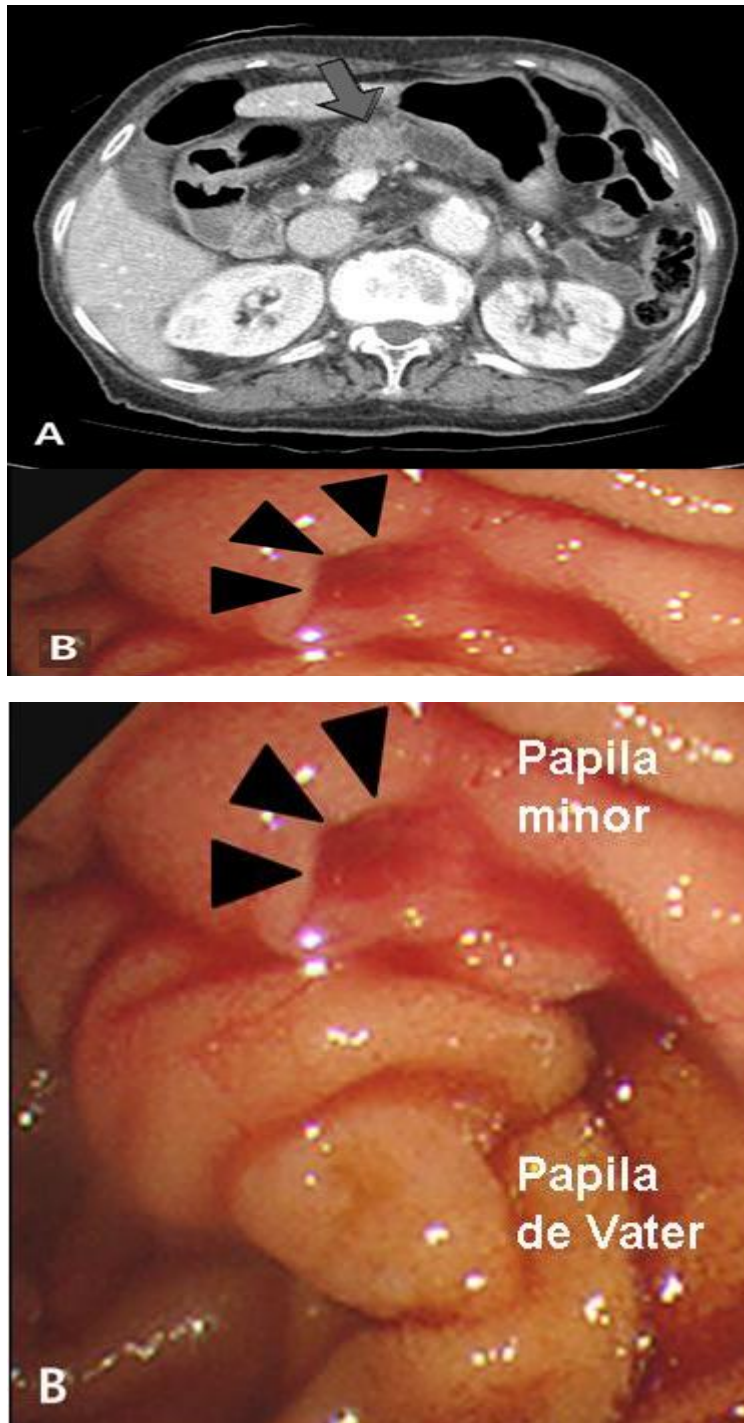


Fig. 1. A. An abdominal CT showed an ovoid mass (arrow) of 3 x 1.8 cm with heterogeneous enhancing, involving the pancreatic body with diffuse main pancreatic duct dilatation. B. A side-viewing endoscopy showed two separate orifices of the duodenal papilla with fresh blood (arrow head) oozing through the cranial orifice in the 1 o'clock position to the other caudal orifice in the 7 o'clock position.

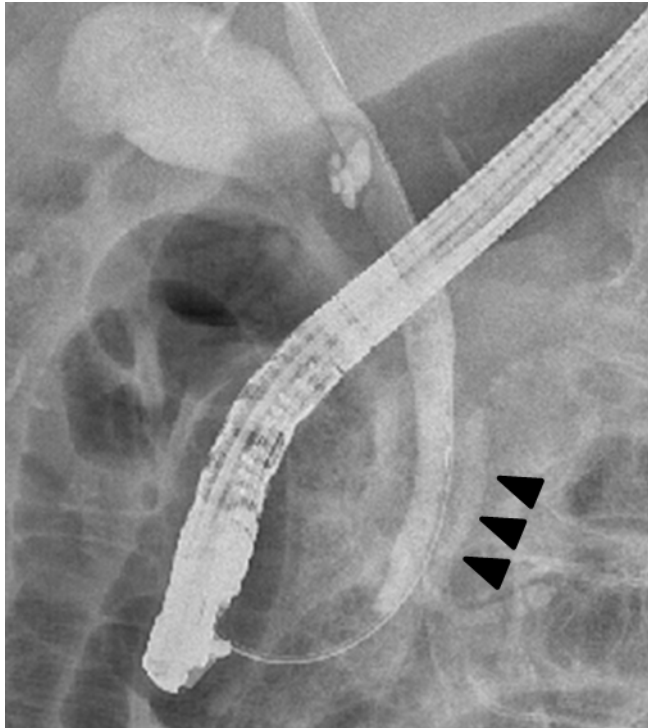


Fig. 2. An endoscopic retrograde cholangiopancreatography demonstrated normal features of the common bile duct and the pancreatic duct (arrows head), with narrowing of the duct below the mid part of the pancreatic duct by ERCP.



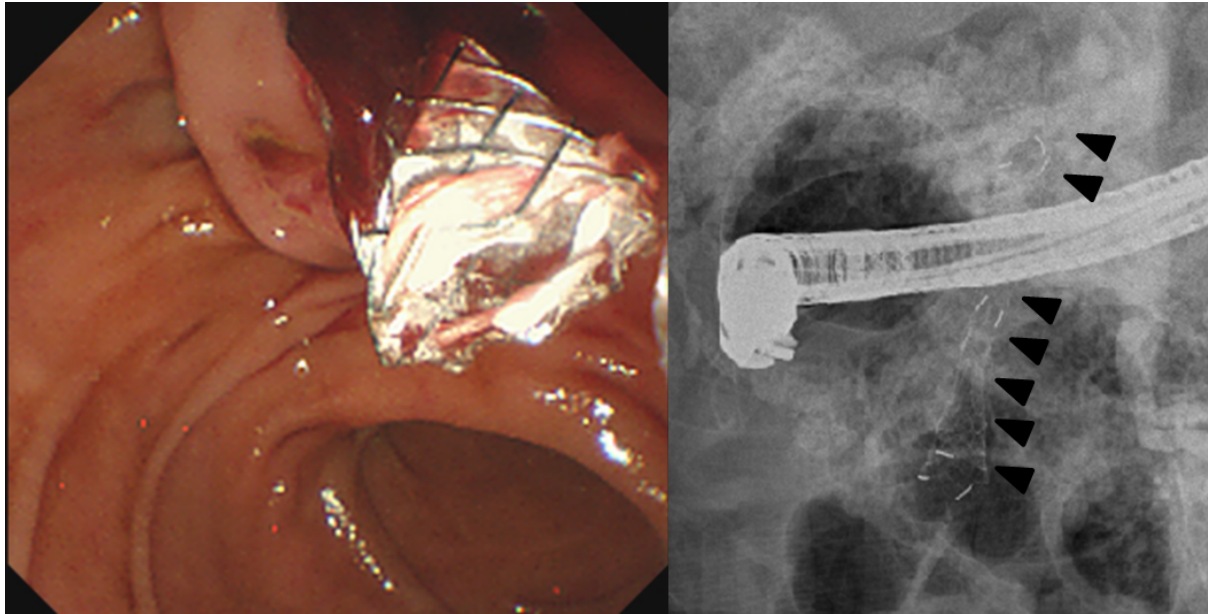


Fig. 3. A fully covered self-expandable metallic stent (SEMS) (arrow) was inserted endoscopically through the pancreatic duct.

#### COMMENTARY

Hemorrhage through the Papilla of Vater may come from the bile duct (hemobilia) (1) or pancreatic duct (hemosuccus). The origin must be borne in mind when only blood is observed in the second duodenal portion during upper gastrointestinal bleeding.

Although the Papilla can be seen with the front view of a gastroscope, it is better to use a side-view duodenoscope if possible. The bleeding usually originates from a fistula between some main vessel and the duct.

Treatment may be angiographic embolization. In the case that we are commenting on, the bleeding was stopped with the insertion of a fully covered metal stent in the pancreas. In a similar way, these stents are used to stop post-sphincterotomy bleeding (2).

Jesús García- Cano

Associated Editor of *The Spanish Journal of Gastroenterology*

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