LETTERS TO THE EDITOR
EDİTÖRE MEKTUPLAR
Gastric aberrant pancreas

Aberrant pankreas

To the Editor,

The pancreatic tissue existing in an organ or tissue distinct from the pancreas is referred to as aberrant pancreas (AP). They are rare submucosal tumors that most commonly consist of pacreatic acini and ducts, but islets can be seen in one-third of the cases. AP is found in 1% to 2% of autopsies and in 0.2% in surgical series (1). AP occurs at all ages and is located in the upper gastrointestinal tract in 70% of cases (2). Here, we describe a case with AP, its endoscopic-histologic features and successful treatment with surgical procedures.

A 41-year-old woman was admitted to our hospital with epigastric pain and bloating. She denied weight loss, changes in bowel habits, hematemesis, hematochezia, or melena. On physical examination, the abdomen was soft and nontender with normal bowel sounds and no masses. Complete blood count, liver enzymes, and abdominal ultrasonography were normal. Upper endoscopy revealed a 0.5 cm in diameter nodular mass with central umbilication at the prepyloric region. Endoscopic biopsy specimen showed gastritis. Gastric wedge resection was performed. Microscopically, pancreatic acini and ducts were seen in the submucosa (Figure 1).

Because patients with AP are usually asymptomatic, the lesion is found incidentally during clinical investigation for other gastroduodenal diseases. On endoscopy, it usually appears as a yellowish, single nodule from 0.2 to 5.5 cm in diameter. Tumors larger than 5 mm often show central umbilication, which is believed to be the site of a draining duct (3). However, central umbilication is not definitive for AP, and it is difficult to differentiate AP from leiomyoma, which is the most common submucosal tumor of the stomach (4). AP sometimes causes symptoms associated with pancreatitis, cyst formation, ulceration, bleeding, obstructive jaundice, and gastric outlet obstruction, but epigastric discomfort is the most frequent complaint. Hase et al. (5) described two types of AP: fusion and separate. Tissue arising in the submucosa and muscularis propria is fusion type and origin only in the submucosa is the separate type; endosonography (EUS) is recommended to distinguish between them. Surgical resection is preferred to endoscopic resection when the muscularis propria is involved.

Because we could not perform EUS and confirm the type of AP, we recommended surgery to our patient. Follow-up data showed that our patient had an uneventful postoperative course and was discharged in good health.

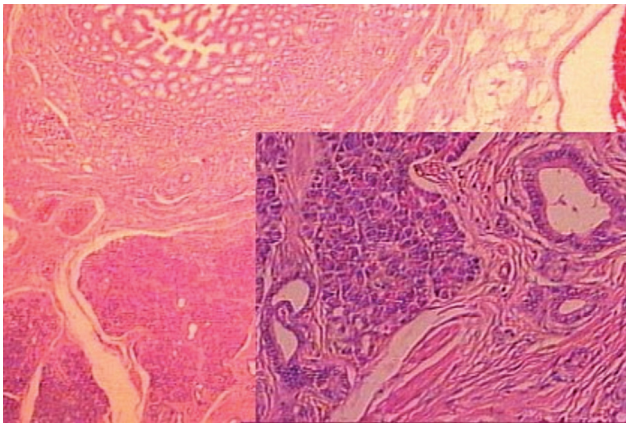

Figure 1. Hematoxylin and eosin-stained sections show pancreatic acini and ducts in the antral submucosa.

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A case of eosinophilic gastritis secondary to ulcerative colitis

Ülseratif kolite sekonder eozinofilik gastrit vakası

To the Editor,

A 51-year-old male with a five-year history of ulcerative colitis presented with nausea, abdominal pain, blood in stool, and diarrhea. Ulcerative colitis reactivation was suspected and the patient was administered glucocorticoid and azathioprine treatment. After alleviation of symptoms, glucocorticoid treatment was tapered. Symptoms recurred in a short period. Laboratory studies revealed elevation in inflammatory parameters and peripheral eosinophilia. The patient underwent endoscopic procedures, which showed polypoid lesions in the stomach (Figure 1) with marked eosinophilic infiltration of the gastric mucosa and inflammation of colonic mucosa. Eosinophilic gastroenteritis (EG) secondary to ulcerative colitis was suspected, and all other causes of EG were excluded. Fortunately, the patient responded to high-dose steroid and azathioprine therapy. Remarkable improvement in symptoms was seen within one week. With resolution of symptoms and peripheral eosinophilia, prednisolone was tapered.

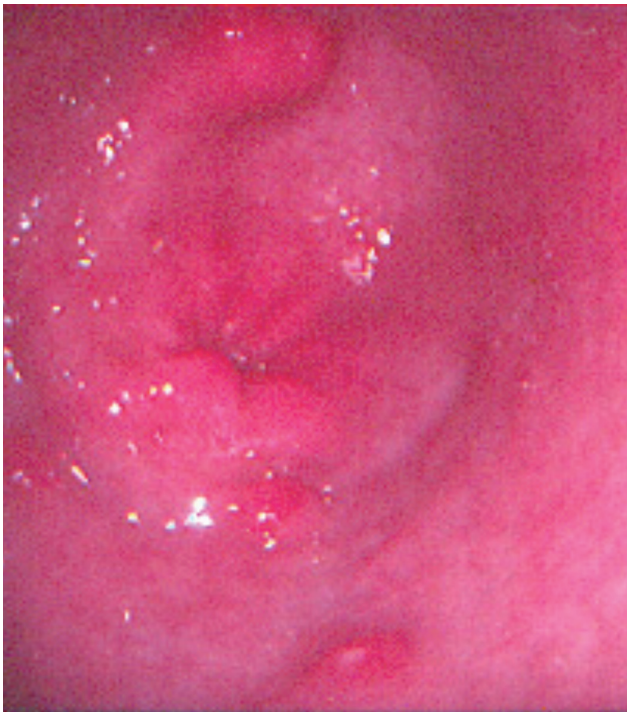

Figure 1. Polipoid lesions in the gastric antrum

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