

LETTER TO THE EDITOR

Concomitant Pancreas Divisum and Double Pylorus: A Case Report

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Dear Sir,

Double pylorus (DP) is a rare condition that is usually discovered incidentally through an upper endoscopy (UE) examination. While acquired DP, which is the most common type, often develops as a complication of peptic ulcer disease (PUD), congenital DP can be isolated associated with other congenital abnormalities such as heterotopic pancreatic tissue or gastric duplication [1, 2]. This article presents the first case of DP associated with pancreas divisum (PD).

A twenty-two-year-old woman was admitted to our hospital because of mild epigastric pain. Her medical history was unremarkable. The laboratory tests that were requested on admission were normal except for amylase 920 U/L (reference range: 60-180 U/L). The patient denied having had any history of PUD or of having used nonsteroidal anti-inflammatory drugs (NSAIDs). A UE examination revealed two pyloric openings into the duodenal bulb. However, there was no evidence of PUD on the UE. The presence of *Helicobacter pylori* was not observed in the histologic examination of the gastric antrum tissue. Magnetic resonance cholangiopancreatogram (MRCP) imaging showed PD (Figure 1 A-B). The patient was treated symptomatically, and she recovered. When the UE and MRCP were repeated for control on the sixth month of the treatment, they demonstrated the same findings as the initial UE and MRCP.

DP is a rare condition consisting of a double communication between the gastric antrum and the duodenal bulb [3]. The condition has a reported endoscopic incidence between 0.02% and 0.08% [1, 4]. In an extensive literature review of all gastrointestinal tract duplications published in English literature, DB was found in only 1 out of 281 reported cases [5]. The coexistence of pancreas divisum and gastric duplication has also been reported by Di Pisa *et al.* [6].

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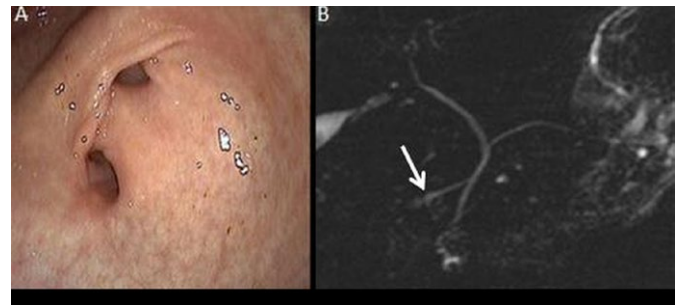


Figure 1. A) Endoscopic appearance of double pylorus, B) MRCP appearance of pancreas divisum. Typically, the accessory duct drains majority of pancreas (white arrow).

In our case, the MRCP showed ventral duct draining of the pancreas. Because of the normal mucosal findings of the gastric antrum and the duodenal bulb on the UE, as well as the negative history of PUD or of any use of NSAIDs, we diagnosed this patient as having DP associated with PD.

To our knowledge, we are reporting the first case in which double pylorus and pancreas divisum occurred at the same time. Consequently, double pylorus might be included in the list of complications that are seen with pancreas divisum.

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