Wirsungocele

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A 19-year-old male, diagnosed to have chronic alcoholic pancreatitis of 1 year duration and on symptomatic treatment was readmitted with symptoms of acute pancreatitis. Routine investigations were unremarkable except for marginally elevated levels of serum lipase and amylase. An endoscopic ultrasound (EUS) was done and was suggestive of chronic pancreatitis with multiple pseudocysts of the head and tail of the pancreas. An endoscopic retrograde cholangiopancreatography was performed which revealed cystic dilatation of the terminal portion of the main pancreatic duct, a ‘Wirsungocele’ (Fig. 1).

Cystic dilatation of the intramural portion of the dorsal pancreatic duct, i.e., ‘Santorinicele’ has been well documented among patients with recurrent acute alcoholic pancreatitis and pancreas divisum [1–3]. But until now, only one case of recurrent acute pancreatitis in association with Wirsungocele has been reported [3]. Baron et al. [1] described the first case of Wirsungocele as an incidental finding in their case report. As the definite cause is unknown, several theories have been proposed to explain the etiology and pathophysiology of terminal cystic ductal dilations. These include decreased autonomic innervation of the sphincter of Oddi leading to inco-ordination of the

Fig. 1 ERCP showing ‘Wirsungocele’ (arrow)

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sphincter and functional obstruction at the papillary orifice [4]. There was no demonstrable periampullary diverticulum or anomalous pancreaticobiliary junction to predispose to ductal wall weakness in our patient. However, the possibility of functional obstruction at the papillary orifice could not be ruled out. The pathophysiological mechanism for Wirsungocele formation is unclear. Whether the association of recurrent acute pancreatitis and Wirsungocele is causative or incidental remains to be established. Similarly, the role of pancreatic endotherapy is also unsubstantiated.

References

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