management (a 2-3 week trial of octreotide), endoscopic management (ERCP with stenting of the pancreatic duct and/or pancreatic sphincterotomy or nasopancreatic drainage), interventional radiologic drainage, and surgical intervention. Defects in the pancreatic tail tend to be low output (and amenable to more conservative therapy), whereas more proximal disruptions are likely to require a more invasive approach. As in many complex, multi-system dilemmas, the choice of treatment likely depends on local expertise, but there is a growing experience that ERCP, in the right hands, offers the right blend of efficacy and minimal invasiveness. The principle by which stenting and sphincterotomy is thought to work is the same as the one that created the fistula in the first place, the relentless pursuit of the path of least resistance. But decreasing ductal pressures alone may not do the trick (especially in the fibrotic and noncompliant gland), and bridging the troubled waters with a stent should, as a general rule, be sought in each case. Pancreatic endotherapy is, however, no causal encounter because serious complications, such as exacerbation of pancreatitis, perforation, or sepsis can occur in up to 1 of 4 cases. We congratulate the authors for a job well done.

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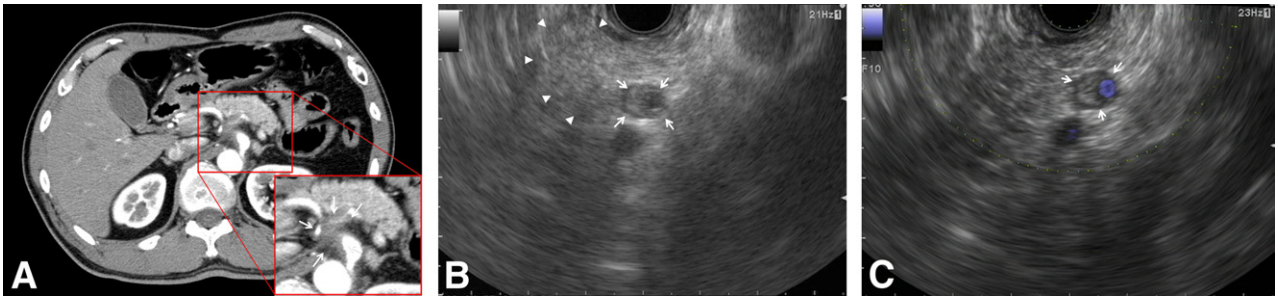
A case of celiac artery dissection diagnosed with EUS



A 50-year-old man who complained of abdominal and back pain had a contrast-enhanced CT that showed a dilated celiac artery and a low-density mass around the celiac artery spreading to the pancreatic body (**A**; *arrows*). We suspected para-aortic invasion of pancreas cancer; however, tumor markers such as carcinoembryonic antigen, CA 19-9, and Dupan-2 were negative, and no avidity was observed on positron emission tomography CT. We performed EUS and discovered an aneurysmal dilatation of the celiac artery (**B**; *arrows*, *arrowheads, pancreas*). Color Doppler imaging showed blood flow within only the true lumen of the aneurysm (**C**; *arrows*), suggesting that what was thought to be vascular invasion of the tumor was actually organization of the false lumen. No treatment was required because the collateral circulation was maintained, and the patient's symptoms gradually and spontaneously resolved.

DISCLOSURE

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Commentary

There is a long list of radiologic curiosities that can masquerade as pancreatic cancer (such as patchy intravenous contrast uptake, chronic pancreatitis, and prominence of the ventral-dorsal confluence); in this case, the initial findings of para-aortic invasion suggested inoperable pancreatic cancer. Clinically, back pain in the setting of a pancreatic mass suggests celiac artery invasion (which also suggests inoperability). Lack of fluorine 18 fluorodeoxyglucose uptake does not rule out early pancreatic adenocarcinoma or a neuroendocrine tumor, which typically is hypometabolic. Isolated celiac artery dissection has been reported in patients with underlying vasculopathy, such as cystic degeneration of the arterial wall or nodular fasciitis. In

patients who are otherwise healthy, however, such dissection is distinctly rare; one case I found involved a 45-year-old man who was bench-pressing with very heavy weights (just one of the reasons I don't go to the gym). EUS is a powerful tool for trouble-shooting suspected mass lesions of the pancreas. It excels over cross-sectional imaging when the nature of lesions smaller than 1 to 2 cm is being interrogated, and real-time Doppler capability can define subtle vascular relationships missed by CT or magnetic resonance imaging. Approximately 10% of Whipple procedures are done unnecessarily (those ultimately revealing benign disease), and the availability of EUS may reduce that figure. The beautiful images presented here (and no doubt even more beautiful to the author's patient!) resulted in a much-appreciated "Focal Point" and a diagnosis without the need for biopsy.

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