A 52-year-old man presented with recurrent right upper quadrant pain of >10 months’ duration. His abdomen was soft, with no tenderness or rebound tenderness. Laboratory tests showed increased white blood cells, serum amylase and lipase levels, and erythrocyte sedimentation rate. Computed tomography revealed obvious thickening of the wall of the second portion of the duodenum by a soft tissue mass showing contrast enhancement (Figure 1A-C). Magnetic resonance imaging revealed a 3.1×3.7-cm duodenal mass, with significant contrast enhancement, and dilatation of the intrahepatic bile ducts, common hepatic duct, and proximal common bile duct (Figure 1D). During pancreaticoduodenectomy, we resected a palpable, soft, moveable duodenal mass measuring 5×6×2 cm. Histology showed large areas of hyperplastic fat acini with abundant eosinophilic cytoplasm. Smooth muscle was interspersed between the acini, and nodules were present (Figure 1E,F). We diagnosed Brunner’s gland adenoma.

A case of duodenal Brunner’s gland adenoma

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Figure 1 Images of Brunner's gland adenoma. (A) Unenhanced computed tomography axial image showing a soft tissue mass with indistinct margins in the second portion of the duodenum. (B) Axial image in the portal venous phase showing continued heterogeneous enhancement of the mass with interspersed fluid-density areas. (C) Computed tomography cholangiopancreatography image showing the relatively sharp margins of the mass, and the arc of the pressure trace on the common bile duct. (D) Contrast-enhanced T1-weighted image showing significant heterogeneous enhancement of the mass. (E) Photomicrograph showing large areas of hyperplastic fat acini in the lesion, with abundant eosinophilic cytoplasm and small round nuclei in the basilar part of each acinus (×40). (F) Photomicrograph showing pancreatic ducts and lobules in the muscular layer of the intestinal wall within the lesion (×100).

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Footnote

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