

## Endoscopic transvaginal drainage and necrosectomy of presacral walled-off pancreatic necrosis

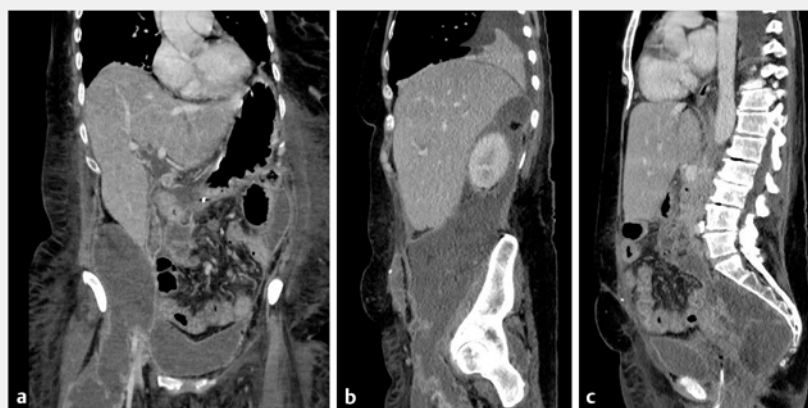
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Transluminal drainage and necrosectomy has become the preferred choice of treatment for complicated walled-off pancreatic necrosis (WON). Transgastric, transduodenal, transrectal, and transcolonic approaches have been described [1–4], but in some cases the location of the WON prevents access through the gastrointestinal tract. We here describe a case of transvaginal drainage and necrosectomy.

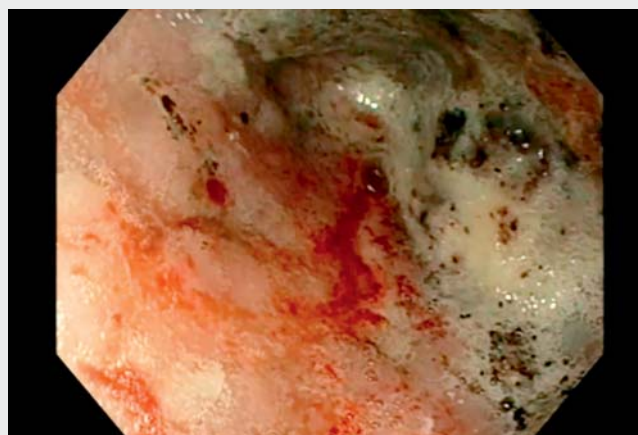
The patient was a 50-year-old woman with Crohn's disease and previous proctocolectomy. She underwent an endoscopic retrograde cholangiopancreatography (ERCP) for common bile duct stones. The procedure was complicated by severe post-ERCP pancreatitis. After 36 days, the patient developed a large WON surrounding the right kidney, extending into the pelvis and the right thigh (► Fig. 1).

The WON was initially drained percutaneously as it was inaccessible from the gastrointestinal tract. After six video-assisted retroperitoneal debridement (VARD) procedures and continuous drainage via multiple percutaneous drains, the right-sided WON had resolved. A residual area of infected presacral necrosis was inaccessible for VARD; however, the patient developed a spontaneous fistula between this area of necrosis and the vagina. Vaginoscopy was performed using a therapeutic gastroscope (► Video 1). Under fluoroscopic guidance, a contrast catheter with guidewire (VisiGlide2; Olympus, Hamburg, Germany) was introduced through the fistula into the area of necrosis. The fistula was balloon dilated to 10 mm and two 12-cm 7-Fr double-pigtail stents were inserted, along with a 7-Fr irrigation catheter (► Fig. 2; ► Video 1).

During three additional procedures, the vaginal fistula was gradually dilated up to 18.5 mm and extensive endoscopic necrosectomy was performed using polypectomy snares until the WON was



► **Fig. 1** Contrast-enhanced computed tomography image of the abdomen 36 days after the onset of pancreatitis showing the distribution of necrosis in the: **a** coronal plane, with extension of the necrosis evident from the retroperitoneum into the right thigh; **b** sagittal plane, with perirenal and intrapelvic extension visible; **c** sagittal plane, with the presacral necrosis that was not accessible for video-assisted retroperitoneal debridement or other endoscopic transluminal approaches.



► **Video 1** Endoscopic transvaginal drainage and necrosectomy is performed for an area of presacral walled-off pancreatic necrosis that was inaccessible from the gastrointestinal tract.

free of debris. During the final procedure, two double-pigtail stents were inserted, which were removed 1 month later. The patient was discharged 81 days after the initial VARD procedure. Currently, 3 years after discharge, there

has been no recurrence of the pancreatitis or pancreatic fluid collection and the patient has no vaginal complaints.

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► **Fig. 2** Contrast-enhanced computed tomography image of the abdomen showing: **a** on day 63 after the onset of pancreatitis (before the initial vaginoscopy), the area of presacral necrosis (arrow); **b** on day 75, the appearance 4 days after the initial vaginoscopy and drain insertion.

## Bibliography

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## Competing interests

The authors declare that they have no conflict of interest.

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