Esophageal stricture following successful resolution of a mediastinal pseudocyst by endoscopic trans-papillary drainage

A 42-year-old alcoholic man had recurrent upper abdominal pain accompanied by breathlessness and right-side pleuritic chest pain for 5 months. Examination revealed right-sided pleural effusion. He had normal hemogram, liver, and renal function tests, normal serum amylase and a normal calcium profile. Thoracentesis from the right-sided pleural effusion revealed no cells, a high protein content (4.3 g/dL), and elevated amylase (2800 IU/L). Tube drainage of the right pleural effusion was done; it continued to drain 200–400 mL/day of clear fluid with a high amylase content.

A contrast-enhanced computed tomography (CECT) scan of the chest and abdomen showed a small abdominal pseudocyst (pancreatic pseudocyst), right-sided pleural effusion, and a 5-cm pseudocyst in the posterior mediastinum compressing the lower end of the esophagus with its proximal dilatation (● Fig. 1). Endoscopic ultrasound (EUS) revealed features of chronic noncalcific pancreatitis along with a mediastinal pseudocyst that was displacing the descending aorta posteriorly (● Fig. 2). Endoscopic retrograde cholangiopancreatography (ERCP) was performed. Contrast-free deep cannulation of the pancreatic duct was achieved (● Fig. 3), and a 5-Fr pancreatic stent was placed.

The patient had marked improvement in his symptoms, with resolution of abdominal pain and cessation of chest tube drainage within 2 weeks of stent insertion. The chest tube was removed, and repeat CECT of the chest and abdomen at 4 weeks showed resolution of all the pseudocysts and pleural effusion.

However, the patient started complaining of dysphagia to solids, which gradually worsened. Endoscopy revealed a non-negotiable stricture at the lower end of the esophagus. EUS with a radial echoendoscope from the mouth of the stricture revealed thickening of the esophageal wall with loss of the layered pattern of the esophageal wall (● Fig. 4). Endoscopic dilation was performed with bougie dilators, and the stricture was gradually dilated up to 15 mm in diameter. With this, there was marked improvement in the pa-

Fig. 1 Contrast-enhanced computed tomography (CECT): mediastinal pseudocyst (white arrows) compressing the esophagus with its proximal dilatation (arrow heads). Also note the right-side pleural effusion (stars) with intercostal draining tube in situ.

Fig. 2 Endoscopic ultrasound (EUS): pseudocyst in the paraesophageal location anterior to the descending aorta.

Fig. 3 Endoscopic retrograde pancreatography (ERP): guide wire taken into the area of pancreatic duct disruption in the mediastinum.

Fig. 4 Endoscopic ultrasound (EUS): marked asymmetrical thickening of the esophageal wall with loss of its layered pattern.

tient's symptoms. After 3 months of follow-up, the patient remained asymptomatic.

In spite of their location, mediastinal pseudocysts rarely cause dysphagia and are usually associated with pleural effusion [1–3]. Conservative medical therapy with somatostatin or its analogues and endoscopic (transpapillary or transmural drainage), surgical, or percutaneous drainage methods have been successfully used for symptomatic mediastinal pancreatic pseudocysts [1]. Resolution is usually uneventful, but sometimes the healing process may cause intense fibrotic

reaction in the surrounding tissues, causing complications [4].

Endoscopy_UCTN_Code_CCL_1AB_2AC_3AD

Competing interests: None

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DOI <http://dx.doi.org/10.1055/s-0031-1291695>
Endoscopy 2012; 44: E121–E122
 © Georg Thieme Verlag KG
 Stuttgart · New York
 ISSN 0013-726X

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