Successful drainage of recurrent pancreatic pseudocyst via a transpapillary and transpancreatic approach, using a conventional cystotome

A 54-year-old patient was previously admitted to our hospital in 2010 with a history of biliary necrotizing pancreatitis and pancreatic fluid collection with necrotic debris projecting into the tail of the pancreas. We carried out endoscopic ultrasound-guided (EUS) transgastric drainage of the superinfected necrotic area. The patient was discharged and 6 months later the pigtailed catheters were removed after complete resolution of the fluid collection. After another 6 months, transabdominal ultrasound showed a large pseudocyst at the same site without any signs of inflammation. The diagnosis was confirmed by computed tomography (CT) (Fig. 1). EUS revealed a large stenosis in the pancreatic duct and there was suspicion of a fistula in relation to the pseudocyst. Transgastric access for pseudocyst drainage was impeded by the presence of multiple varices because of splenic vein thrombosis. We therefore chose a transpapillary approach for draining the pseudocyst (diameter 10 cm).

Endoscopic retrograde pancreatography (ERP) confirmed the presence of filiform stenosis in the pancreatic main duct and a prestenotic communication into the pseudocyst (Fig. 2). While a guide wire passed through the stenosis, neither an ERCP cannula nor a biliary dilatation catheter could be passed across it. After taking informed consent, another attempt was made to place the guide wire again via the stenosis into the pancreatic pseudocyst (Fig. 3). A cystotome was placed in the stenosis and moved under blended current into the pseudocyst (Fig. 4). A nasocystic tube was placed, which spontaneously drained 500 mL of clear cystic fluid (Fig. 5). A follow-up CT scan revealed rapid and complete resolution of the pseudocyst, and 4 days later the patient had been discharged with a 17-cm, 7-F Amsterdam stent. There were no signs of discomfort or inflammation. This case demonstrates that access to a pancreatic pseudocyst for transpapillary drainage through a stenosed duct can be gained with a cystotome under blended current, so long as the guide wire is safely placed inside the pseudocyst.

Fig. 1 Computed tomography (CT) scan showing pancreatic pseudocyst in a patient with history of biliary necrotizing pancreatitis and pancreatic fluid collection with necrotic debris projecting into the tail of the pancreas.

Fig. 2 Stenosis of the pancreatic duct and the pancreatic fistula.

Fig. 3 Guide wire inside the pseudocyst.

Fig. 4 Guide wire-assisted transpancreatic access to the pseudocyst using a cystotome.

Fig. 5 Computed tomography (CT) scan after transpapillary transpancreatic drainage.

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Competing interests: None

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