Endoscopic ultrasound-guided transmural drainage of a pancreatic collection: case report of a massive hemoperitoneum without intracystic bleeding

Fig. 1 Computed tomographic scan shows a massive hemoperitoneum without intracystic bleeding and with strictly intraperitoneal active bleeding.

Fig. 2 The source of the bleeding is at a distance from the point of puncture of the cystogastrostomy, at the level of the gastric wall.

A 51-year-old woman was referred for the management of a painful pseudocyst, 50 mm in diameter, in the tail of the pancreas. The pseudocyst had mature walls and was close to the gastrointestinal lumen [1]. The patient had no ascites and no coagulation disorder. Segmental portal hypertension was noted on computed tomographic examination. A cystogastrostomy was done with a 10-Fr cystotome, and two 7-Fr, 7-cm plastic prostheses were introduced after dilation of the orifice with an 8-mm balloon. There were no operative adverse events. In the recovery room, the patient developed hemodynamic instability, with a hemoglobin level of 4.5 g/dL. An angioscan revealed a massive hemoperitoneum with strictly intraperitoneal active bleeding (Fig. 1). An emergency caudal splenopancreatectomy was performed. The source of the bleeding was at a distance from the point of puncture of

the cystogastrostomy, at the level of the gastric wall (Fig. 2). The pseudocyst walls were intact, and there were no sequelae related to coagulation of the cystostomy, confirmed afterward by histologic examination. The patient remained in intensive care for 2 days and was discharged 15 days after admission without any recurrence of adverse events. Endoscopic ultrasound-guided transmural drainage of a pseudocyst is an effective and safe procedure, with a median success rate of 89%, an average morbidity rate of 13%, and a mortality rate of 0.3% [2]. Major adverse events are bleeding, pneumoperitoneum, and infection. Rarer adverse events are pancreatitis, pancreatic fistula, stent migration and tract dehiscence, Ogilvie syndrome, pneumothorax, and air embolism [3–5]. Although hemorrhage is a well-known complication, this is the first described case of hemoperitoneum without rupture,

intracystic bleeding, or direct trauma to an interposed vessel. We suspect laceration of a vessel located in the intraperitoneal gastric wall, secondary to the balloon dilation. Awareness is necessary, and excessive dilation should be avoided in a patient with segmental portal hypertension who is undergoing EUS-guided transmural drainage of a pancreatic collection.

Endoscopy_UCTN_Code_CPL_1AL_2AD

Competing interests: None

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DOI <http://dx.doi.org/10.1055/s-0034-1391858>
Endoscopy 2015; 47: E244
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

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