Transient gastric ischemia as a complication of cystotomy in endoscopic pancreatic pseudocyst drainage

A 70-year-old man was referred to our department for endoscopic drainage of a pancreatic pseudocyst. He had acute pancreatitis as a result of choledocolithiasis, which developed following a cholecystectomy 2 years previously. Computed tomography (CT) revealed a 7-cm cystic lesion in the head of the pancreas, which was compatible with a pseudocyst. Endoscopic ultrasonography (EUS) was performed and showed a 7-cm homogeneous anechoic lesion. Under EUS guidance the lesion was punctured using a 19-G needle through the posterior wall of the distal antrum (● Fig. 1). After a guide-wire had been passed into the cyst, cystotomy was performed. The access to the cyst was difficult, and during cystotomy ischemic changes were observed in the posterior wall and greater curvature of the antrum (● Fig. 2). The ischemia completely resolved after nearly 5 minutes. Complete cystotomy was achieved only after dissection of the fistula (● Fig. 3) using a needle-knife, which was inserted through an upper endoscope. Balloon dilation was performed, and two plastic 7-Fr double-pigtail stents were placed (● Fig. 4). The following day, the patient had fever and mild abdominal pain. CT scan showed the stent to be in a good position but an abscess was apparent between the stomach and the lesion, in the trajectory of the stent (● Fig. 5). Antibiotic treatment with

ciprofloxacin and metronidazole was initiated. Then, 3 days after the procedure, the patient experienced rectal bleeding, with a 4g/dL drop in hemoglobin levels (from 12.8 to 8.6g/dL). Upper endoscopy was performed, and showed a blood clot adherent to the stent, with no active bleeding. CT scan was repeated 1 week later, and showed resolution of the abscess. At this point, the patient resumed oral feeding and was discharged with no symptoms after 2 weeks of antibiotic treatment.

Endoscopic drainage is an effective procedure for pancreatic pseudocyst [1]. Complications include stents migration, bleeding, perforation, and infection [2]. There have been no previous cases of gastric ischemia reported in the literature.

Endoscopy_UCTN_Code_CPL_1AL_2AD

Competing interests: None

João Santos-Antunes^{1,2}, Pedro Moutinho-Ribeiro¹, Guilherme Macedo¹

¹ Department of Gastroenterology, Faculty of Medicine, Centro Hospitalar S. João, Porto, Portugal

² Department of Biochemistry (U38-FCT), Faculty of Medicine, University of Porto, Portugal

Fig. 5 Computed tomography scan image showing the pancreatic pseudocyst and, anteriorly, a second collection in the trajectory of the stents.

Fig. 1 Fine-needle aspiration of the pancreatic pseudocyst.

Fig. 2 Ischemic changes were observed in the gastric antrum during the cystotomy attempt.

Fig. 3 Endoscopic image of the gastrocystic fistula.

Fig. 4 Endoscopic image showing the pigtail stents in the stomach.

References

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DOI <http://dx.doi.org/10.1055/s-0034-1393176>
Endoscopy 2015; 47: E483–E484
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author

João Santos-Antunes, MD
Departments of Gastroenterology
and Biochemistry
Faculty of Medicine
Hospital de São João
Alameda Professor Hernâni Monteiro
4200-319 Porto
Portugal
Fax: +351-22-5025766
joao.claudio.antunes@gmail.com