Disconnected pancreatic duct syndrome – Wait! Why not try one more time?

A 42-year-old man with a history of necrotizing pancreatitis complicated by pancreatic fluid collections (PFCs) who underwent percutaneous drainage for 4 months but still had a persistent external fistula with high amylase activity in the drainage fluid was referred. A previous endoscopic retrograde cholangiopancreatography (ERCP) in another endoscopy center had suggested complete main pancreatic duct (MPD) disruption (▶ Fig. 1). Contrast injection through the drainage catheter showed no opacification of the proximal MPD (▶ Fig. 2a). During a second ERCP, carried out in our endoscopy center, contrast injection through the major duodenal papilla also demonstrated complete cutoff of the proximal MPD and no opacification of the distal MPD (▶ Fig. 2b). Therefore, the diagnosis of complete MPD disruption was made and normally surgical treatment would have been considered. Fortunately, in this case, after several attempts by the endoscopist, the disruption site was traversed with a guidewire, and the route from the MPD complete cutoff to the site of the PFCs was not opacified by any contrast. A pancreatic stent was placed to drain the PFCs (▶ Fig. 2c and ▶ Fig. 3; ▶ Video 1) and immediately there was cessation of fluid drainage from the percutaneous drainage catheter. The patient had an uneventful recovery and was discharged 1 day later, with surgery having been avoided.

The diagnosis of disconnected pancreatic duct syndrome (DPDS) is usually confirmed on ERCP if there is extravasation of injected contrast from the MPD without filling of the distal MPD [1]. Once the diagnosis of complete MPD disruption has been made, it is often treated by surgery [2], while endotherapy is effective for partial pancreatic ductal disruption [3]. However, we have shown in this case, where both percutaneous and endoscopic contrast injection had demonstrated complete cutoff of the pancreatic duct, that there is still a possibility that the guidewire may cross the site of the disruption and that a stent can be placed to drain the pancreatic juice or PFC. But only if we try!

Endoscopy_UCTN_Code_TTT_1AR_2AI

Acknowledgment

Dr. Yu Bai is supported by the National Natural Science Foundation of China (Grant No. 81670473) and National Key R&D Program of China (2017YFC1308800) and Three Engineering Training Funds in Shenzhen (No. SYLY201718).
Competing interests

None

The authors

Shu-Ling Wang*, Sheng-Bing Zhao*, Tian Xia, Zhao-Shen Li, Yu Bai
Department of Gastroenterology, Changhai Hospital, Second Military Medical University, Shanghai, China

Corresponding author

Yu Bai, MD, PhD
Department of Gastroenterology, Changhai Hospital, Second Military Medical University, Shanghai, China

baiyu1998@hotmail.com

* Contributed equally to this work

References


Bibliography

DOI https://doi.org/10.1055/a-0605-3076
Published online: 12.6.2018
Endoscopy 2018; 50: E188–E189
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X