A case of massive bleeding after endoscopic sphincterotomy in a patient with a history of large walled-off pancreatic necrosis in the area of the pancreatic groove

Walled-off pancreatic necrosis (WOPN) associated with severe acute pancreatitis is sometimes fatal [1]. Interventional endoscopic ultrasonography has improved clinical outcomes; however, the long-term prognosis in such cases remains unknown [2,3]. WOPN extending to the area of the pancreatic groove has been reported to cause structural abnormalities to the bile duct, with the presence of abnormal blood vessels [4].

A 73-year-old man was hospitalized for choledocholithiasis. He had undergone direct endoscopic necrosectomy 7 years previously for a large WOPN due to idiopathic severe acute pancreatitis (Fig. 1). The WOPN had extended widely into the groove area. Magnetic resonance cholangiopancreatography for recurrent epigastric pain revealed multiple choledocholithiasis. Computed tomography revealed pneumobilia but no pseudoaneurysm or abnormal vascular growth in the pancreatic arcade.

Initial ERCP showed abnormal hardness of the major papilla and severe structural distal bile duct abnormality without a duodenal diverticulum (Fig. 3). A medi-
A case of a patient who underwent endoscopic sphincterotomy (EST) for walled-off pancreatic necrosis (WOPN) and developed massive arterial bleeding. Immediate balloon compression was ineffective, but rapid hemostasis was achieved by placing a self-expandable metallic stent (SEMS; fully covered type, 10 mm × 6 cm). The SEMS was safely removed without rebleeding 14 days after the ERCP, and all stones flowed out naturally through the SEMS. The authors highlight the importance of considering unexpected blood vessels when performing EST beyond a small incision. They also discuss the severe structural abnormality of the distal bile duct and hardness of the major papilla as a possible result of inflammatory spread of the WOPN. The study concludes with a call for further investigation into the recommended direction and length of incision for EST in advanced inflamed WOPN. The authors also note the need for caution when performing EST beyond a small incision to avoid rebleeding.

**References**


**Bibliography**

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