A 42-year-old alcoholic man had recurrent upper abdominal pain accompanied by breathlessness and right-side pleuritic chest pain for 5 months. Examination revealed right-sided pleural effusion. He had normal hemogram, liver, and renal function tests, normal serum amylase and a normal calcium profile. Thoracentesis from the right-sided pleural effusion revealed no cells, a high protein content (4.3 g/dL), and elevated amylase (2800 IU/L). Tube drainage of the right pleural effusion was done; it continued to drain 200–400 mL/day of clear fluid with a high amylase content.

A contrast-enhanced computed tomography (CECT) scan of the chest and abdomen showed a small abdominal pseudocyst (pancreatic pseudocyst), right-sided pleural effusion, and a 5-cm pseudocyst in the posterior mediastinum compressing the lower end of the esophagus with its proximal dilatation (Fig. 1). Endoscopic ultrasound (EUS) revealed features of chronic noncalcific pancreatitis along with a mediastinal pseudocyst that was displacing the descending aorta posteriorly (Fig. 2). Endoscopic retrograde cholangiopancreatography (ERCP) was performed. Contrast-free deep cannulation of the pancreatic duct was achieved (Fig. 3), and a 5-Fr pancreatic stent was placed.

The patient had marked improvement in his symptoms, with resolution of abdominal pain and cessation of chest tube drainage within 2 weeks of stent insertion. The chest tube was removed, and repeat CECT of the chest and abdomen at 4 weeks showed resolution of all the pseudocysts and pleural effusion.

However, the patient started complaining of dysphagia to solids, which gradually worsened. Endoscopy revealed a non-negotiable stricture at the lower end of the esophagus. EUS with a radial echoendoscope from the mouth of the stricture revealed thickening of the esophageal wall with loss of the layered pattern of the esophageal wall (Fig. 4). Endoscopic dilation was performed with bougie dilators, and the stricture was gradually dilated up to 15 mm in diameter. With this, there was marked improvement in the pa-
tient’s symptoms. After 3 months of follow-up, the patient remained asymptomatic.

In spite of their location, mediastinal pseudocysts rarely cause dysphagia and are usually associated with pleural effusion [1–3]. Conservative medical therapy with somatostatin or its analogues and endoscopic (transpapillary or transmural drainage), surgical, or percutaneous drainage methods have been successfully used for symptomatic mediastinal pancreatic pseudocysts [1]. Resolution is usually uneventful, but sometimes the healing process may cause intense fibrotic reaction in the surrounding tissues, causing complications [4].

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