Percutaneous direct-endoscopic necrosectomy for walled-off pancreatic necrosis

We report a case where percutaneous direct-endoscopic necrosectomy was successfully used to treat walled-off pancreatic necrosis (WOPN) that could not be accessed via the transluminal approach.

A 36-year-old woman with severe alcoholic pancreatitis was referred to our institute. The computed tomography (CT) scan showed extensive WOPN (larger diameter 26 cm) spreading from the level of the pancreas to the pelvic floor (Fig. 1).

*Citrobacter freundii* was detected from the aspiration fluid obtained from the WOPN. Transluminal observation of the WOPN by endoscopic ultrasonography was not possible, because of the presence of an inflammatory duodenal stricture.

The patient initially underwent percutaneous drainage 17 days after the onset of pancreatitis. A stent was placed in the right urinary tract to prevent urinary duct injury during necrosectomy. In total, two percutaneous drainage catheters were placed in the right flank region and right lower abdomen. During the second session, the percutaneous fistula in the right flank was dilated up to 18 mm with a balloon dilator (CRETM wire-guided balloon dilator; Boston Scientific, Natik, Massachusetts, USA). Next, a flexible overtube (diameter 20 mm), whose length had been shortened by 20 cm, was placed to maintain carbon dioxide insufflation of the cavity (Fig. 2).

Direct necrosectomy was performed using a gastroscope through the overtube. All the procedures were performed under intravenous anesthesia. The maximum duration of necrosectomy was 2 hours. Abundant solid and purulent necrotic material was removed using a snare, a basket catheter, and alligator forceps. At the end of each necrosectomy session, three drainage catheters (diameter 24 Fr) were placed to maintain the fistula, and two irrigation catheters were also placed (Fig. 3). After 11 necrosectomy sessions, the patient was discharged without complications.

Endoscopic necrosectomy via the percutaneous approach can be used as a treatment option if the WOPN is located adjacent to the abdominal wall.
Competing interests: None


Department of Gastroenterology, Graduate School of Medicine, The University of Tokyo, Tokyo, Japan

References


Bibliography

DOI http://dx.doi.org/10.1055/s-0032-1309927
Endoscopy 2013; 45: E44 – E45
© Georg Thieme Verlag KG
Stuttgart · New York
ISSN 0013-726X

Corresponding author
N. Yamamoto, MD
Department of Gastroenterology
Graduate School of Medicine
The University of Tokyo
7-3-1 Hongo, Bunkyo-ku
Tokyo 113-8655
Japan
Fax: +81-3-38140021
natsuyo@tke.att.ne.jp