Endoscopic repair of a massive postoperative pancreatic juice leak through the bile duct stump due to pancreatobiliary maljunction

A 55-year-old woman underwent supra-pancreatic resection of a large choledochal cyst, Todani type IVA, associated with pancreatobiliary maljunction (PBMJ), Komi type IIb [1].

On the first postoperative day, a large amount (500–600 mL) of an amylase and lipase-rich secretion was noted to be draining out of the Jackson-Pratt drain. An endoscopic retrograde cholangiopancreatography (ERCP) was performed to evaluate the pancreatobiliary anatomy, which confirmed the PBMJ. Pancreatic duct sphincterotomy was performed and was followed by insertion of a 7-Fr pancreatic plastic stent. Despite this therapy, there was persistent drainage of pancreatic enzyme-rich juice (500 mL) through the Jackson-Pratt drain. A repeat ERCP clearly demonstrated the PBMJ and evidence of ongoing leakage.

Endoscopic therapy consisted of sphincterotomy of both the pancreatic and bile duct sphincters, along with pancreatic duct stenting. Once the bile duct sphincter had been incised, the leak resolved within 2 weeks. Knowledge of this anatomical variant based on the Komi classification is important when dealing with suspected postoperative injury to the pancreas and/or pancreatic duct [1, 2].

Competing interests: None

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Fig. 2  Schematic showing the classification of pancreaticobiliary maljunction (PBMJ), as proposed by Komi. Ap, accessory pancreatic duct; Ch, common channel; Cch, choledochal cyst; D, duodenum; P, pancreatic duct; Vp, ventral pancreatic duct.

References

Bibliography
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