Endoscopic ultrasound-guided transmural drainage of a pancreatic collection: case report of a massive hemoperitoneum without intracystic bleeding

A 51-year-old woman was referred for the management of a painful pseudocyst, 50 mm in diameter, in the tail of the pancreas. The pseudocyst had mature walls and was close to the gastrointestinal lumen [1]. The patient had no ascites and no coagulation disorder. Segmental portal hypertension was noted on computed tomographic examination.

A cystogastrostomy was done with a 10-Fr cystotome, and two 7-Fr, 7-cm plastic prostheses were introduced after dilation of the orifice with an 8-mm balloon. There were no operative adverse events. In the recovery room, the patient developed hemodynamic instability, with a hemoglobin level of 4.5 g/dL.

An angioscan revealed a massive hemoperitoneum with strictly intraperitoneal active bleeding (○ Fig. 1). An emergency caudal splenopancreatectomy was performed. The source of the bleeding was at a distance from the point of puncture of the cystogastrostomy, at the level of the gastric wall (○ Fig. 2). The pseudocyst walls were intact, and there were no sequelae related to coagulation of the cystostomy, confirmed afterward by histologic examination. The patient remained in intensive care for 2 days and was discharged 15 days after admission without any recurrence of adverse events.

Endoscopic ultrasound-guided transmural drainage of a pseudocyst is an effective and safe procedure, with a median success rate of 89%, an average morbidity rate of 13%, and a mortality rate of 0.3% [2]. Major adverse events are bleeding, pseudoperitoneum, and infection. Rarer adverse events are pancreatitis, pancreatic fistula, stent migration and tract dehiscence, Ogilvie syndrome, pneumothorax, and air embolism [3–5].

Although hemorrhage is a well-known complication, this is the first described case of hemoperitoneum without rupture, intracystic bleeding, or direct trauma to an interposed vessel. We suspect laceration of a vessel located in the intraperitoneal gastric wall, secondary to the balloon dilation. Awareness is necessary, and excessive dilation should be avoided in a patient with segmental portal hypertension who is undergoing EUS-guided transmural drainage of a pancreatic collection.

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