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, pancreatic fluid collection drainage, and naso-cystic drain. J Gastroenterol Hepatol 2011; 26: 1504 – 1508


Competing interests: None

References

1 Seewald S, Ang TL, Teng KC et al. EUS-guided drainage of pancreatic pseudocysts, abscesses and infected necrosis. Dig Endosc 2009; 21 (Suppl. 01): S61 – S65