Transient gastric ischemia as a complication of cystotomy in endoscopic pancreatic pseudocyst drainage

A 70-year-old man was referred to our department for endoscopic drainage of a pancreatic pseudocyst. He had acute pancreatitis as a result of cholecodolithiasis, which developed following a cholecystectomy 2 years previously. Computed tomography (CT) revealed a 7-cm cystic lesion in the head of the pancreas, which was compatible with a pseudocyst.

Endoscopic ultrasonography (EUS) was performed and showed a 7-cm homogeneous anechoic lesion. Under EUS guidance the lesion was punctured using a 19-G needle through the posterior wall of the distal antrum (Fig. 1). After a guide-wire had been passed into the cyst, cystotomy was performed. The access to the cyst was difficult, and during cystotomy ischemic changes were observed in the posterior wall and greater curvature of the antrum (Fig. 2). The ischemia completely resolved after nearly 5 minutes. Complete cystotomy was achieved only after dissection of the fistula (Fig. 3) using a needle-knife, which was inserted through an upper endoscope. Balloon dilation was performed, and two plastic 7-Fr double-pigtail stents were placed (Fig. 4). Antibiotic treatment with ciprofloxacin and metronidazole was initiated. Then, 3 days after the procedure, the patient experienced rectal bleeding, with a 4 g/dL drop in hemoglobin levels (from 12.8 to 8.6 g/dL). Upper endoscopy was performed, and showed a blood clot adherent to the stent, with no active bleeding. CT scan was repeated 1 week later, and showed resolution of the abscess. At this point, the patient resumed oral feeding and was discharged with no symptoms after 2 weeks of antibiotic treatment.

Endoscopic drainage is an effective procedure for pancreatic pseudocyst [1]. Complications include stents migration, bleeding, perforation, and infection [2]. There have been no previous cases of gastric ischemia reported in the literature.

Competing interests: None

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References

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