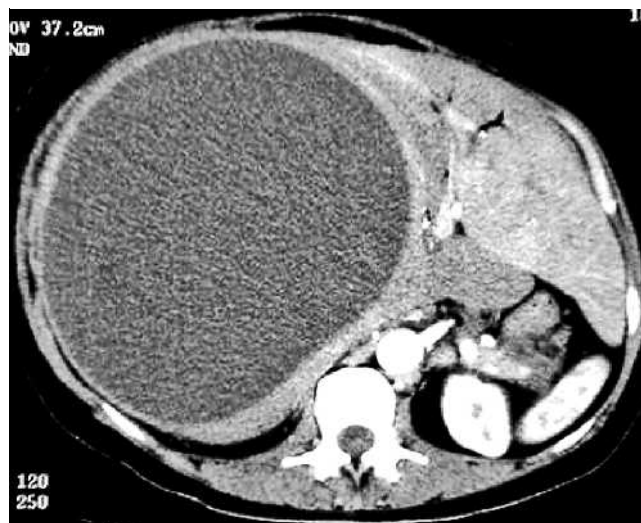


## Subcapsular intrahepatic hematoma: an unusual complication of ERCP

Hemorrhagic complications following endoscopic retrograde cholangiopancreatography (ERCP) are generally manifest as gastrointestinal hemorrhage, and published studies report an incidence of 0.8% to 4% [1,2].

Intrahepatic bleeding as a complication of ERCP has not been reported previously, although guide wire perforation of the biliary tree resulting in intrahepatic biloma and intraperitoneal bleeding from gastroduodenal, pancreatoduodenal, and hepatic arteries has been described [3–5]. This case illustrates an unreported complication of ERCP resulting in significant morbidity.

A 51-year-old female presented with right-sided abdominal discomfort, and tender hepatomegaly extending to the right iliac fossa 3 months after an ERCP for a retained common bile duct stone and jaundice. Following duct cannulation and contrast injection, a tracer guide wire was maneuvered past the stone, and a 1 cm sphincterotomy was carried out, and the stone retrieved following a single balloon trawl. The patient had normal hematological and clotting parameters. Following the procedure the patient developed right upper abdominal pain and collapsed requiring intensive resuscitation. Hyperamylasemia was absent. An urgent computed tomography (CT) scan revealed a large collection (10 × 13 cm) consistent with a hematoma within the lateral inferoposterior aspect of the right lobe of the liver. Ultrasound-guided drainage of blood was performed with a pigtail catheter. Ultrasonographic monitoring was performed at 1 and 3 months, revealing an increase in size of the hematoma from 17 × 15 × 9 cm to 23 × 18 × 16 cm serially. Contrast-enhanced CT was performed and showed the lesion to be entirely intrahepatic (● **Figure 1**). Under ultrasound guidance, 5600 ml of bile-free liquid he-



**Figure 1** Large subcapsular intrahepatic hematoma after endoscopic retrograde cholangiopancreatography.

matoma was drained percutaneously, with successful resolution at 3 months of follow up. This case was managed successfully using a percutaneous drainage; however, this approach does raise the possibility of further hemorrhage following drainage, and is only recommended where facilities for embolisation and surgery exist.

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