A CASE REPORT OF PSEUDOCYST OF PANCREAS

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ABSTRACT

A 54 year old female came with complaints of left side lower abdominal pain for past 8 months, which was gradual in onset and progressive in nature. No history of vomiting. Known hypertensive for past 2 years and was on regular treatment. Patient was operated electively under spinal anaesthesia. Trans-cystoGastrostomy was done.

INTRODUCTION

Pseudocyst of the pancreas is a localized fluid collection that is rich in amylase and other pancreatic enzymes and is surrounded by a wall of fibrous tissue that is not lined by epithelium[1]. Pseudocysts are connected with the pancreatic duct system, either as a direct communication or indirectly via the pancreatic parenchyma. They are caused by pancreatic ductal disruption following increased pancreatic ductal pressure, either due to stenosis, calculi or protein plugs obstructing the main pancreatic ductal system, or as a result of pancreatic necrosis following an attack of acute pancreatitis[2,3]. Pseudocysts are a common clinical problem and complicate the course of chronic pancreatitis in 30% to 40% of patients[4].

CASE REPORT

A 54 year old female came with complaints of left side lower abdominal pain for past 8 months, which was gradual in onset and progressive in nature. No history of vomiting. Known hypertensive for past 2 years and was on regular treatment.

On examination patient’s GC was fair with pulse 78/min and BP 140/90 mm Hg. Local examination showed equal movements of all quadrants with respiration with no scars or sinuses; abdomen was soft and tenderness was present over periumblical region. Percussion notes were normal and bowel sounds were heard.

Haemogram revealed Hb 11.89%. blood urea 19 mg/dl and creatinine 0.7 mg/dl. Serology were non-reactive. Cytological examination were negative for malignant cells.

Patient was operated electively under spinal anaesthesia. Trans-cystoGastrostomy was done.

Under aseptic precautions, a upper midline incision made and incision deepened in layers upto rectus muscle. Peritoneum identified and opened, adhesions were released from posterior wall of peritoneum. Anterior border of stomach is opened transversely and posterior side of stomach identified, incised and opened and around 400ml of fluid was drained. Continuous interlocking sutures made encircling the cyst wall and posterior border of stomach.
DISCUSSION

Pseudocyst formation is a common complication of both acute and chronic pancreatitis. Most pseudocysts occur in peripancreatic area and very rarely do they reach the mediastinum. Pancreatic pseudocysts are cystic cavities encased by reactive granulation or fibrous tissue, in or around the pancreas. The presence of a well-defined wall distinguishes a pseudocyst from an acute fluid collection seen in acute pancreatitis. The Atlanta classification is widely used to distinguish acute fluid collection from acute and chronic pseudocysts. Acute fluid collection appears early in the course of acute pancreatitis and lacks a wall of inflammatory tissue while acute pseudocysts are composed of pancreatic fluid enclosed by a wall of inflammatory tissue and occur as a result of acute pancreatitis or trauma to the pancreas. Chronic pseudocysts, although also composed of pancreatic fluid enclosed by a wall of inflammatory tissue, occurs only as a consequence of chronic pancreatitis without any attack of preceding acute pancreatitis.[1]

Pancreatic ductal obstruction due to stricture or stones leading to an elevated intraductal pressure, results in pseudocyst formation. Pseudocyst can complicate 7% to 15% of episodes of acute pancreatitis and 20% to 25% of cases of chronic pancreatitis.[2] Spontaneous resolution occurs in more than 50% of cases but complications can occur in up to 5% to 40% of cases as reported in various studies.[3] Common complications include infection, intracystic hemorrhage, enlargement, and mass effect causing bile duct or bowel obstruction and formation of internal or external fistula.[3]

Pancreatic pseudocysts are the result of acute or chronic pancreatitis and are the most common cystic lesions of the pancreas, accounting for 75%-80% of such lesions. The most common symptoms are abdominal pain, nausea and vomiting, although they can be asymptomatic. Abdominal CT is an excellent choice for initial imaging. EUS plays an important role in differentiating pseudocyst from other cystic lesions of the pancreas and can greatly assist in transmural endoscopic drainage. Initial management consists of supportive care. Persistent symptoms and the development of complications warrant invasive intervention. In recent years, the endoscopic approach has gained popularity with surgery reserved for patients who had failed endoscopic or percutaneous drainage. A tailored therapeutic approach taking into consideration patient preferences and involving multidisciplinary team of therapeutic endoscopist, interventional radiologist and pancreatic surgeon should be considered in all cases.

Drainage options are as follows:
- Percutaneous catheter drainage – The procedure of choice for infected pseudocysts; although recurrence and failure rates are high, it may be a good temporizing measure
• Endoscopic drainage, either transpapillary (via ERCP) or transmural – The complication rate appears to decrease and efficacy to increase with experience
• Surgical drainage – The criterion standard; internal drainage is the procedure of choice, but laparoscopic drainage has yielded good results in some cases

No medications are specific to the treatment of pancreatic pseudocysts. Antibiotics and octreotide may be useful adjuncts in some cases.

REFERENCES