A case of massive bleeding after endoscopic sphincterotomy in a patient with a history of large walled-off pancreatic necrosis in the area of the pancreatic groove

Walled-off pancreatic necrosis (WOPN) associated with severe acute pancreatitis is sometimes fatal [1]. Interventional endoscopic ultrasonography has improved clinical outcomes; however, the long-term prognosis in such cases remains unknown [2,3]. WOPN extending to the area of the pancreatic groove has been reported to cause structural abnormalities to the bile duct, with the presence of abnormal blood vessels [4].

A 73-year-old man was hospitalized for choledocholithiasis. He had undergone direct endoscopic necrosectomy 7 years previously for a large WOPN due to idiopathic severe acute pancreatitis (Fig. 1). The WOPN had extended widely into the groove area. Magnetic resonance cholangiopancreatography revealed multiple choledocholithiasis. Computed tomography revealed pneumobilia but no pseudoaneurysm or abnormal vascular growth in the pancreatic arcade.

Fig. 1 In a 73-year-old man hospitalized for choledocholithiasis, walled-off pancreatic necrosis (WOPN) 7 years previously had extended widely into the area of the pancreatic groove.

Video 1 Endoscopic hemostasis with placement of a self-expandable metallic stent for massive postendoscopic sphincterotomy bleeding.

Video 2 Computed tomography revealed pneumobilia in the distal bile duct (arrowheads) but no pseudoaneurysm or abnormal vascular growth in the pancreatic arcade.

Fig. 2 Computed tomography revealed pneumobilia in the distal bile duct (arrowheads) but no pseudoaneurysm or abnormal vascular growth in the pancreatic arcade.

Fig. 3 Hardness of the ampulla of the major papilla (black arrowheads) and severe structural abnormality of the distal bile duct (white arrowheads) were considered to be the results of inflammatory spread of the WOPN.
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