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 for recurrent epigastric pain revealed multiple choledocholithiasis. Computed tomography revealed pneumobilia but no pseudoaneurysm or abnormal vascular growth in the pancreatic arcade.

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

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.

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.
A case of walled-off pancreatic necrosis (WOPN) was managed by endoscopic sphincterotomy (EST) and placement of a self-expandable metallic stent (SEMS) to achieve hemostasis. The patient went into shock due to massive arterial bleeding, but immediate balloon compression was ineffective. Rapid hemostasis was later achieved by placement of a SEMS (fully covered type, 10 mm × 6 cm) and no transfusion was required. Most stones flowed out naturally through the SEMS; the last was extracted at the same time that the SEMS was removed. The severity of the structural abnormality of the distal bile duct and hardness of the major papilla were considered to be the results of inflammatory spread of the WOPN. Advanced walled-off WOPN is present in the groove area, and EST beyond a small incision was considered to be ineffective. For this reason, it is important to be careful about the presence of unexpected blood vessels when performing EST beyond a small incision.

Competing interests

The authors declare that they have no conflict of interest.

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