A 24-year-old man presented with a gradually progressive abdominal distension over 6 months. He received bilateral ventriculoperitoneal shunts 4 years back for tubercular meningitis with multiple revisions since then. At presentation, he had a functioning right ventriculo-pleural shunt and a blocked left ventriculoperitoneal shunt with right double J stent. Examination revealed markings of bilateral shunts in the neck with gross abdominal distension (▶Fig. 1). A contrast-enhanced computed tomography scan of the abdomen revealed a large, encysted collection (16×25.6×41 cm) occupying the whole abdomen, displacing the bowel loops peripherally, with no free fluid and a left ventriculoperitoneal shunt entering the collection (▶Fig. 2), also visualized on endoscopic ultrasound (EUS) (▶Fig. 3). The neurosurgery team planned to remove the blocked ventriculoperitoneal shunt only after drainage of the collection to prevent further fluid accumulation. Exploring different treatment options in a multidisciplinary team meeting, the patient opted for EUS-guided drainage.

Under fluoroscopic and endoscopic guidance, standard steps of an EUS-guided cysto-enterostomy were followed (assessment using linear echoendoscope [GIF UCT180; Olympus, Tokyo, Japan], puncture with a 19-G needle [EZ Shot3 Plus; Olympus Medical], fluid aspiration, guidewire passed and coiled within the cavity, tract dilatation using an 8.5-Fr cystotome [CYSTO085U; G-Flex, Nivelles, Belgium]), and a 10-Fr nasocystic drain was passed deep down in the pelvis (▶Video 1). Post-procedure, 11 liters of fluid was drained (cerebrospinal fluid [CSF]: lymphocytic, high protein, gene-expert negative, sterile, positive beta-2 transferrin) and distension decreased remarkably. A post-procedure X-ray of the abdomen was done (▶Fig. 4) along with CT, which revealed complete resolution (▶Fig. 5); the left ventriculoperitoneal shunt was removed subsequently. Thereafter, the nasocystic drain was removed under endoscopic guidance and the patient discharged, with no recurrence 1 year post-procedure.
contamination with EUS-drainage, we used two strategies: 1) dilatation of the tract with an 8.5-Fr cystotome with placement of a 10-Fr nasocystic drain to avoid over-dilatation; and 2) choosing a nasocystic drain over a transmural pigtail stent to drain the fluid outside, negating the chances of retro-contamination from intestinal contents [5]. To the best of our knowledge, this is the first report of EUS-guided drainage of such a giant CSF pseudocyst and appears to be a safe and effective alternative.

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Conflict of Interest

The authors declare that they have no conflict of interest.

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