

## Successful drainage of recurrent pancreatic pseudocyst via a transpapillary and transpancreatic approach, using a conventional cystotome

A 54-year-old patient was previously admitted to our hospital in 2010 with a history of biliary necrotizing pancreatitis and pancreatic fluid collection with necrotic debris projecting into the tail of the pancreas. We carried out endoscopic ultrasound-guided (EUS) transgastric drainage of the superinfected necrotic area. The patient was discharged and 6 months later the pigtailed catheters were removed after complete resolution of the fluid collection. After another 6 months, transabdominal ultrasound showed a large pseudocyst at the same site without any signs of inflammation. The diagnosis was confirmed by computed tomography (CT) (▶ Fig. 1). EUS revealed a large stenosis in the pancreatic duct and there was suspicion of a fistula in relation to the pseudocyst. Transgastric access for pseudocyst drainage was impeded by the presence of multiple varices because of splenic vein thrombosis. We therefore chose a transpapillary approach for draining the pseudocyst (diameter 10 cm).

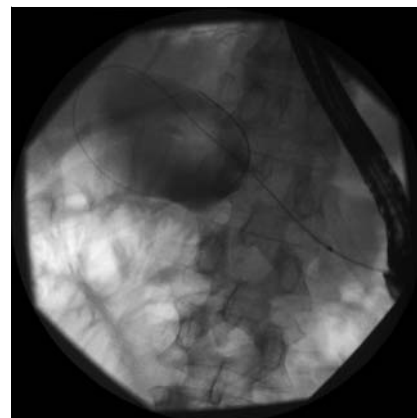
Endoscopic retrograde pancreatography (ERP) confirmed the presence of filiform stenosis in the pancreatic main duct and a prestenotic communication into the pseudocyst (▶ Fig. 2). While a guide wire passed through the stenosis, neither an ERCP cannula nor a biliary dilatation catheter could be passed across it. After taking informed consent, another attempt was made to place the guide wire again via the stenosis into the pancreatic pseudocyst (▶ Fig. 3). A cystotome was placed in the stenosis and moved under blended current into the pseudocyst (▶ Fig. 4). A nasocystic tube was placed, which spontaneously drained 500 mL of clear cystic fluid (▶ Fig. 5). A follow-up CT scan revealed rapid and complete resolution of the pseudocyst, and 4 days later the patient had been discharged with a 17-cm, 7-F Amsterdam stent. There were no signs of discomfort or inflammation. This case demonstrates that access to a pancreatic pseudocyst for transpapillary drainage through a stenosed duct can be gained with a cystotome under blended current, so long as the guide wire is safely placed inside the pseudocyst.



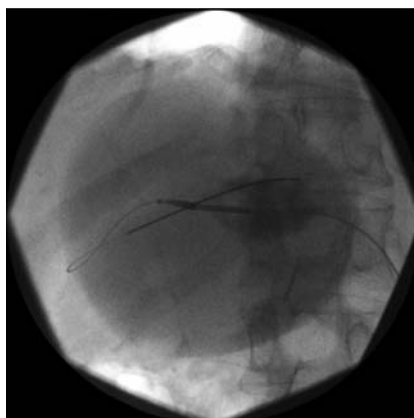
**Fig. 1** Computed tomography (CT) scan showing pancreatic pseudocyst in a patient with history of biliary necrotizing pancreatitis and pancreatic fluid collection with necrotic debris projecting into the tail of the pancreas.



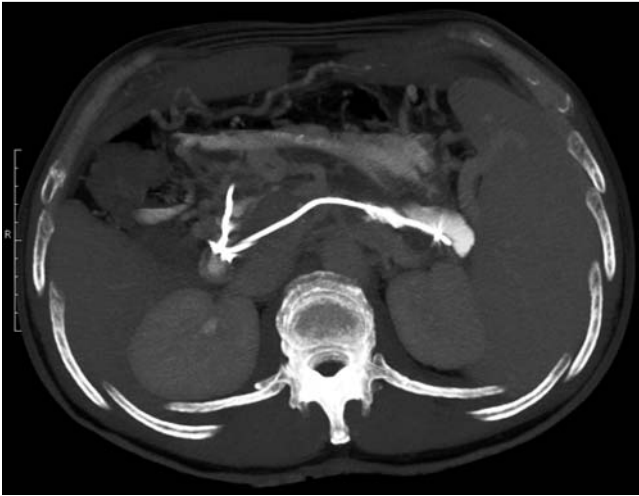
**Fig. 2** Stenosis of the pancreatic duct and the pancreatic fistula.



**Fig. 3** Guide wire inside the pseudocyst.



**Fig. 4** Guide wire-assisted transpancreatic access to the pseudocyst using a cystotome.



**Fig. 5** Computed tomography (CT) scan after transpapillary transpancreatic drainage.

Endoscopy\_UCTN\_Code\_TTT\_1AR\_2AI

**Competing interests:** None

**M. Kraft<sup>1</sup>, P. Simon<sup>1</sup>, C. Nitsche<sup>1</sup>,  
S. Runge<sup>1</sup>, N. Hahn<sup>1</sup>, R. Puls<sup>2</sup>,  
M. M. Lerch<sup>1</sup>**

<sup>1</sup> Department of Internal Medicine A,  
University Medicine Greifswald,  
Greifswald, Germany

<sup>2</sup> Department of Radiology and Neuro-  
radiology, University Medicine Greifswald,  
Greifswald, Germany

#### **Bibliography**

**DOI** [http://dx.doi.org/  
10.1055/s-0032-1306793](http://dx.doi.org/10.1055/s-0032-1306793)  
Endoscopy 2012; 44: E186–E187  
© Georg Thieme Verlag KG  
Stuttgart · New York  
ISSN 0013-726X

#### **Corresponding author**

**M. Kraft**

Department of Internal Medicine A  
University Medicine Greifswald  
Ernst-Moritz-Arndt Universität Greifswald  
Friedrich-Löffler-Str. 23a  
17475 Greifswald  
Germany  
Fax: +49-3834-867234  
[matthias.kraft@uni-greifswald.de](mailto:matthias.kraft@uni-greifswald.de)