Fatal complication after endoscopic ultrasound-guided celiac plexus neurolysis

A 57-year-old woman with a diagnosis of idiopathic recurrent pancreatitis and progressive epigastric pain radiating to her back was admitted to the hospital. Abdominal computed tomography (CT) showed a suspicious 3-cm pancreatic head mass involving the superior mesenteric artery (SMA) and vein. Endoscopic ultrasound (EUS) showed the suspicious pancreatic head mass with bile duct and main pancreatic duct dilatation and changes compatible with chronic pancreatitis. However, EUS-guided fine needle aspiration cytology was negative on three occasions. EUS-guided celiac plexus neurolysis (EUS-CPN) was carried out using a 19-gauge needle. Absolute alcohol (10cc) and bupivacaine 0.5% (5 cc) were injected on each side of the celiac takeoff. Color Doppler imaging after the procedure revealed the permeability of the SMA and celiac takeoff.

After the procedure, the patient experienced stabbing pain radiating to the back, with nausea, hypotension, and fever. CT demonstrated complete thrombosis of the celiac takeoff, as well as wall thickening and bubble-like pneumatosis of the stomach, duodenum, jejunum, ileum loops, and ascending colon. Signs of hepatic infarction of segments I and III, and near-total right-kidney and splenic infarction were discovered. Conservative management was carried out and the patient died 8 days later.

Major complications have rarely been reported using EUS-CPN or EUS-guided celiac plexus block (Table 1) [1–7]. The present case is the first to document a fatal outcome. The sclerosing effect of absolute ethanol, arterial embolisms after injection, and vasospasm could explain the necrosis of organs distant to the celiac takeoff [8]. All cases of major complications due to CPN, except one, were reported in the setting of chronic pancreatitis (Table 1). The issue of using CPN in patients with chronic pancreatitis is still a matter of debate [9]. In conclusion, major complications of CPN can include death. It may be preferable to limit EUS-guided CPN to patients with histologically proven cancers.

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Competing interests: None


1 Gastroenterology Department, University Hospital of Canary Islands, La Laguna, Tenerife, Spain
2 Internal Medicine Department, Gastroenterology Unit, Alhossien Hospital, Alazhar University, Cairo, Egypt
3 Gastroenterology Department, Saint Luc Hospital, Centre Hospitalier de l’université de Montréal, Montreal, Canada

References

1 O’Toole TM, Schmulewitz N. Complication rates of EUS-guided celiac plexus blockade and neurolysis: results of a large case series. Endoscopy 2009; 41: 593 – 597

Table 1:

<table>
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<th>Author</th>
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<th>Indication</th>
<th>Technique</th>
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<td>Gress et al. [6]</td>
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<td>1 Retroperitoneal bleeding</td>
<td>CP</td>
<td>Bilateral</td>
<td>Alcohol + bupivacaine</td>
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<td></td>
<td></td>
<td>1 Retroperitoneal abscess</td>
<td></td>
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<td>Triamcinolone + bupivacaine</td>
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<td>Mahajan et al. [4]</td>
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<td>1 Empyema</td>
<td>CP</td>
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<td>Muscatiello et al. [3]</td>
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<td>1 Ischemia</td>
<td>CP</td>
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<td>1 Ischemia/dead</td>
<td>PC?, CP</td>
<td>Bilateral</td>
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CP, chronic pancreatitis; PC, pancreatic cancer.

Bibliography

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Corresponding author

A. V. Sahai, MD
Division of Gastroenterology
CHUM
L’Hôpital Saint Luc
1058 Rue Saint Denis
Montreal
Quebec H2X3J4
Canada
anandvsahai@gmail.com

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