Endoscopic ultrasound-guided transgastric drainage of a complex multiloculated peritoneal fluid collection as rare complication of lupus peritonitis

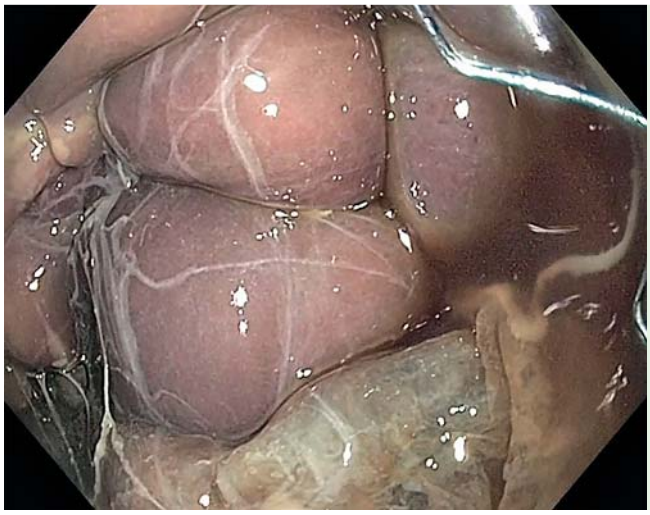
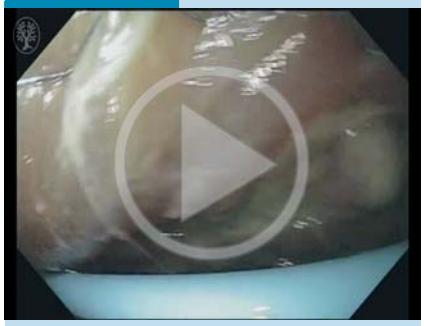


Fig. 1 Endoscopic appearance of the cyst cavity showing small amount of fluid, thin membranous septae, and whitish, cheesy-looking material.

Video 1



Endoscopic appearance of the cyst cavity.

A 23-year-old woman with an 8-year history of systemic lupus erythematosus (SLE) complicated by recurrent peritonitis presented with abdominal pain and distension.

Abdominal computed tomography (CT) demonstrated a new 12×15×23 cm fluid collection in the mid-abdomen that was separate from the adnexa and without intracystic gas. Ultrasound demonstrated a complex multiloculated fluid collection with innumerable septations. Ultrasound-guided aspirate of a cystic portion yielded serosanguinous fluid with a nucleated cell count of 20 775, 95 % neutrophils, and normal amylase, lipase, and CEA. Results of Gram staining, acid-fast staining, and bacterial and fungal cultures of the aspirate were negative. Interventional radiology-guided placement of a percutaneous pigtail catheter yielded minimal drainage, and abdominal pain and distension persisted.

Endoscopic ultrasound (EUS) showed a complex, thick-walled, loculated fluid collection that was separate from the stomach, pancreas, spleen, and kidneys. EUS-guided cystgastrostomy was performed with an 18×60 mm fully covered metal stent (TaeWoong Medical, Gyeonggi-do, South Korea). Endoscopic evaluation of the cyst cavity showed a small amount of fluid, thin membranous septae, and whitish, cheesy-looking material. Biopsies from the cavity wall showed necrotic tissue of uncertain etiology.

On repeat endoscopy (**Fig. 1**, **Video 1**), the thin septae were bluntly dissected using the tip of the endoscope, and larger chunks of reddish tissue were removed using a snare and Roth net. Repeat biopsies showed suppurative inflammation, liquefactive necrosis, and fibrinous thrombus. The patient's symptoms resolved, and repeat CT 2 months later demonstrated resolution of the collection. EUS confirmed this finding, and the cystgastrostomy stent was removed uneventfully.

At 1-year follow-up, the patient had no signs or symptoms suggestive of fluid re-accumulation.

Based on the inflammatory picture of the biopsied cavity walls with negative histologic, microbiologic, and cytologic analysis, we suspect this complex multiloculated collection was a rare complication of lupus peritonitis. This report highlights the diagnostic and therapeutic role of EUS-guided cystgastrostomy in the management of this rare complication of SLE.

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Competing interests: None

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Bibliography
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