Hemorrhagic complications following endoscopic retrograde cholangiopancreato−
ography (ERCP) are generally manifest as gastrointestinal hemorrhage, and pub−
lished studies report an incidence of 0.8 % to 4 % [1,2].
Intrahepatic bleeding as a complication of ERCP has not been reported previously,
although guide wire perforation of the biliary tree resulting in intrahepatic bilo−
ma and intraperitoneal bleeding from gastroduodenal, pancreatoduodenal, and
hepatic arteries has been described [3–5]. This case illustrates an unreported
complication of ERCP resulting in significant morbidity.
A 51−year−old female presented with right−sided abdominal discomfort, and
tender hepatomegaly extending to the right iliac fossa 3 months after an ERCP
for a retained common bile duct stone and jaundice. Following duct cannulation
and contrast injection, a tracer guide wire was maneuvered past the stone, and a
1 cm sphincterotomy was carried out, and the stone retrieved following a single
balloon trawl. The patient had normal hematological and clotting parameters. Fol−
lowing the procedure the patient developed right upper abdominal pain and col−
lapsed requiring intensive resuscitation. Hyperamylasemia was absent. An urgent
computed tomography (CT) scan revealed a large collection (10×13 cm) consistent
with a hematoma within the lateral infero−posterior aspect of the right lobe of the
liver. Ultrasound−guided drainage of blood was performed with a pigtail cath−
er. Ultrasonographic monitoring was performed at 1 and 3 months, revealing an increase in size of the hematoma from 17 × 15 × 9 cm to 23 × 18 × 16 cm serially.
Contrast−enhanced CT was performed and showed the lesion to be entirely in−
trahepatic (Figure 1). Under ultrasound guidance, 5600 ml of bile−free liquid he−
momia was drained percutaneously, with successful resolution at 3 months of follow up. This case was managed success−
fully using a percutaneous drainage; however, this approach does raise the possibility of further hemorrhage follow−
ing drainage, and is only recommended where facilities for embozhouisation and sur−
ergy exist.

Endoscopy_UCTN_Code_CPL_1AK_2AC
Endoscopy_UCTN_Code_CPL_1AK_2AD
Endoscopy_UCTN_Code_CPL_1AK_2AF

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Endoscopy 2007; 39: E150
© Georg Thieme Verlag KG Stuttgart · New York ·
ISSN 0013−726X

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Figure 1 Large sub−capsular intrahepatic hematoma after endo−
scopic retrograde cholangiopancreato−
graphy.