Intrahepatic pancreatic pseudocyst: A case report

Key words: Pseudocyst. Pancreatic.

Dear Editor,

We report a 46-years-old woman diagnosed in 2010 as having pseudocysts after alcoholic chronic pancreatitis (CP) and followed with endoscopic ultrasound (EUS). At this consultation, she complained of epigastric pain radiating into belt, intensified in the last two weeks. Laboratory tests showed amylase of 794 UI/L and amylasuria of 16,900 UI/L; and CT reported uncomplicated hepatic (Fig. 1) and pancreatic (Fig. 2) cysts. With a diagnosis of acute exacerbation of chronic pancreatitis, conservative treatment with inhibitors of proton pump, meperidine and metamizol and nasojejunal feeding tube was introduced. Pancreatic secretory inhibitory drugs were not administered. A 10 cm pseudocyst was drained to relieve pain, checking the simultaneous decrease of liver lesions. The analysis of the amylase showed 114,000 UI/L.

The sonographic control after 6 weeks revealed a decrease of intrahepatic cystic images, but the larger pancreatic pseudocyst persisted, causing pain due to gastric compression. After therapeutic EUS-guided transgastric drainage, the patient progressed satisfactorily. Twelve months later, she remained asymptomatic, with almost complete resolution of the lesions.

Discussion

A significant number of patients with chronic pancreatitis remain asymptomatic until the appearance of complications (1,2), which will determine the clinical course of the disease: Pseudocysts (25-30%), common bile duct stenosis (40-50%) and even pancreatic cancer (3%) (3). Pancreatic pseudocysts are described in multiple extra-pancreatic locations (20%) (1). The intrahepatic location is exceptional, usually asymptomatic and more common in the left lobe (1). As pathophysiological mechanism, the effect of pancreatic proteolytic enzymes, which allows the formation of pseudocysts in so many different areas as the liver, pleura, mediastinum, and retroperitoneum (1,4), is proposed. Some authors suggest the hepatoduodenal ligament as a way of dissemination (5). It is suspected by imaging techniques, in the presence of liver cystic lesion in the course of acute pancreatitis or exacerbations; diagnostic confirmation is established by elevated amylase in the intracystic liquid (6). The treatment of pancreatic pseudocysts located in the liver is conservative because most resolve spontaneously, reserving percutaneous drainage or surgery for symptomatic or complicated cases (1,5), although there is no

Fig. 1. The liver had cysts affecting the caudate lobe and segment 4.
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References


consensus. In our case, probably the largest pseudocyst was in continuity with liver lesions; hence, EUS+ cystogastrostomy was therapeutic.

Fig. 2. CT image showing the pancreas replaced by large cysts (7x10 cm in head-body of the pancreas and 4,7x2,5 cm in pancreatic tail).