Endoscopic management of late complication of blunt traumatic total pancreatic transection

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CASE REPORT

An 11-year-old girl was admitted elsewhere due to severe abdominal pain after a fall with abdominal blunt trauma. CT-scan showed total pancreatic transection of the distal body with suspected injury of main pancreatic duct (Fig. 1). Conservative approach with antibiotics and total parenteral nutrition was decided due to her clinical stability. On day 12, she deteriorated clinically; ultrasound showed an 8 cm pseudocyst that was percutaneously drained. Initially she improved, but on day 37 she developed alimentary intolerance, and on day 55 she was referred to us with septic shock, to perform endoscopic drainage, under piperacillin/tazobactam.

During endoscopic ultrasound, a 5 cm anechoic lesion (Fig. 2) was found in the distal pancreatic body. Transgastric puncture was performed and, over a guide-wire, the fistula was created with a cystotome, followed by balloon dilation (Fig. 3). Two 7 Fr double pigtail stents were placed (Fig. 4). Fluid and blood cultures were positive for Pseudomonas aeruginosa, and amikacin was added.

She had a favourable evolution, starting oral feeding 5 days later, and was discharged asymptomatic after two
weeks. Six months later, MRI showed no signs of pancreatic lesion.

**DISCUSSION**

Immediate management of blunt traumatic pancreatic transection is controversial, since the literature is based on case reports or series. Previous reports showed good outcomes with endoscopic, surgical treatment and even with conservative management in clinically stable patients (1,2).

Management of late complications are even rarely described (3). Clinical deterioration with septic shock demanded undoubtedly an aggressive treatment, with cystogastrostomy, percutaneous drainage or laparotomy. In our case, a minimally invasive approach was decided, with an excellent outcome.

**REFERENCES**