

Hemosuccus Pancreaticus on Endoscopy

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CASE REPORT

A 55-year-old man with chronic alcohol use presented with epigastric pain radiating backward, vomiting, and 1 day of decreased colostomy output (created 1 year earlier for an infected hernia-repair mesh). He had no history of pancreatitis. Computed tomography angiography of the abdomen revealed pancreatic fat stranding, peripancreatic head fluid collection, and a portal vein thrombus (Figure 1). Heparin drip was started. On day 4, the patient developed maroon stools in the colostomy bag, requiring transfusion of 2 units of red blood cells. A magnetic resonance cholangiopancreatography found a 3.1 and a 2.6 cm necrotic fluid collection filled with debris and hemorrhage at the pancreatic head (Figure 2). An emergent esophagogastroduodenoscopy revealed a blood clot protruding from the ampulla (Figure 3). Next, interventional radiology performed a same-day visceral angiography; they discovered and coiled an eroded gastroduodenal artery and pancreaticoduodenal arcades of the superior mesenteric artery (Figure 4). This resolved the patient's bleeding. Roughly 20% of moderately severe acute pancreatitis cases have local complications (eg, pseudocysts, necrosis, and hemosuccus pancreaticus).¹ Hemosuccus pancreaticus is a rare cause of upper gastrointestinal bleeding, estimated at 1/1,500 cases, translating to difficult/delayed diagnosis and high mortality (overall estimated at 9.6%; 90% if untreated).² It is defined as bleeding into the pancreatic duct and often related to inflammatory pancreatic diseases, pancreatic pseudocysts, and pancreatolithiasis.³ Workup with imaging such as magnetic resonance cholangiopancreatography or the gold-standard computed tomography angiography should be pursued when it is suspected. Endoscopy may make the diagnosis

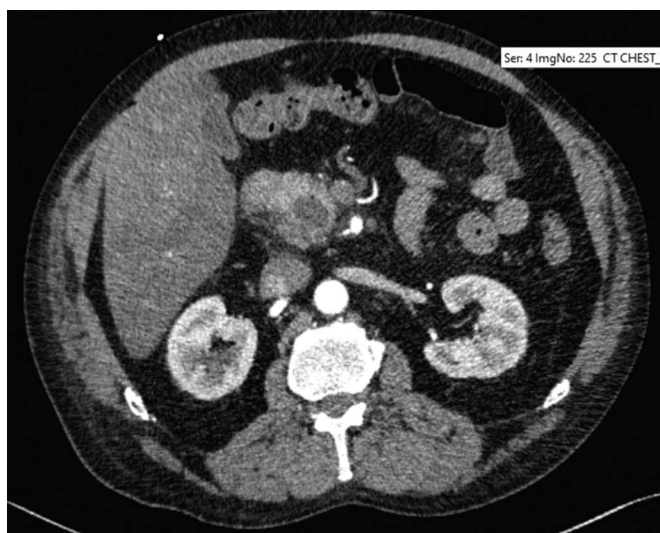


Figure 1. Computed tomography abdomen showing peripancreatic fat stranding with a hypodense area in the pancreatic head/uncinate.

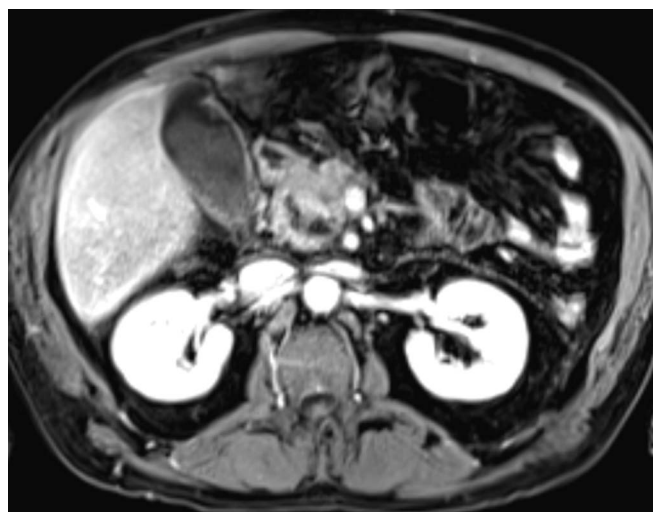


Figure 2. Magnetic resonance imaging of abdomen showing acute pancreatitis with necrotic collections containing fluid, debris, hemorrhage.

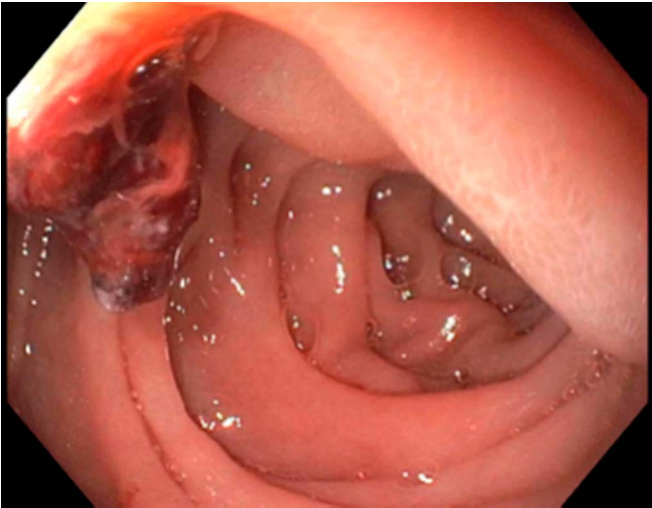


Figure 3. Endoscopy revealing blood clot protruding from ampulla.

in up to 64% of patients and should be performed to rule out other causes of bleeding.⁴ Intermittent bleeding renders visualization difficult, although side-viewing endoscopy may significantly enhance diagnostic yields.⁴ Endoscopic ultrasound and endoscopic retrograde cholangiopancreatography may also aid in detecting filling defects of the pancreatic duct.⁴ Visceral angiography successfully treats over 79% of cases, although severe cases may require pancreaticoduodenectomy.⁵

DISCLOSURES

Author contribution: S.L.—drafting and critical revisions to the article, literature review, provided images, and is the guarantor. M.G.—critical revisions and approval of the article.

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Figure 4. Angiography showing eroded gastroduodenal artery.

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