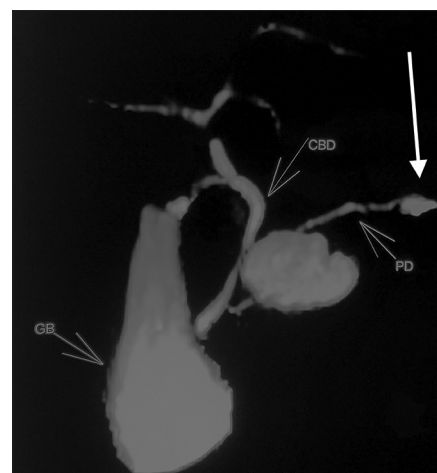


# EUS-guided pancreatic rendezvous for management of pancreaticopleural fistula with an undilated duct and pancreas divisum

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A 33-year-old male, case of acute necrotizing pancreatitis, presented with a pancreatopleural fistula with massive right pleural effusion. There was persistent output from an intercostal drain in the right thorax. Magnetic resonance cholangiopancreatography showed pancreas divisum type II with leak from the tail of the pancreas tracking to the right pleura, with collection in the region of the head of the pancreas [Figure 1]. Endoscopic retrograde pancreatography was attempted twice through the minor papilla but failed despite precut sphincterotomy [Figure 2a]. EUS-guided rendezvous (RV) was considered due to failure of access. EUS showed 1.7-mm pancreatic duct (PD) in the body of the pancreas [Figure 2b], which was punctured using a 22G FNA needle [Figure 2c]. After contrast injection, 0.018” guidewire was passed across into the duodenum [Figure 2d]. Scope was changed to duodenoscope while maintaining guidewire position. The guidewire was drawn out through the duodenoscope using rat-tooth forceps. An endoscopic retrograde cholangiopancreatography cannula was



**Figure 1.** Magnetic resonance cholangiopancreatography showing pancreas divisum with leak from the tail of the pancreas with collection in the region of the neck of the pancreas

then passed across into the PD and guidewire was changed to 0.025”, passed till the tail of the

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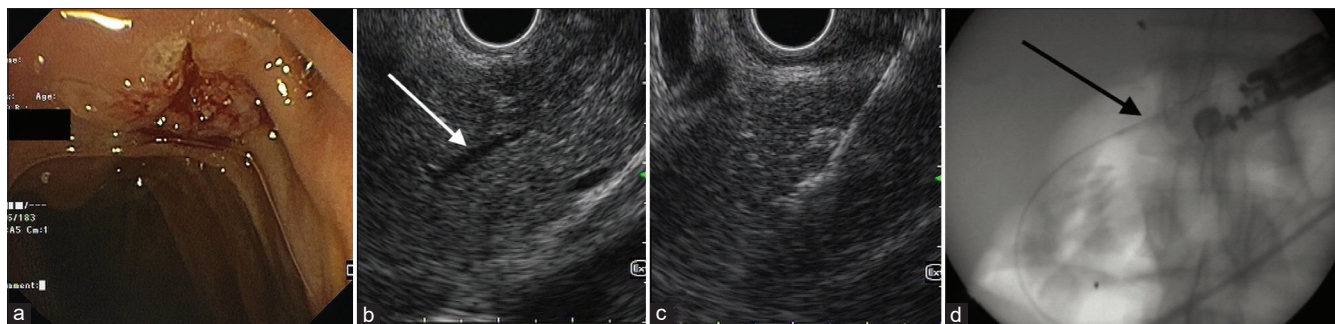
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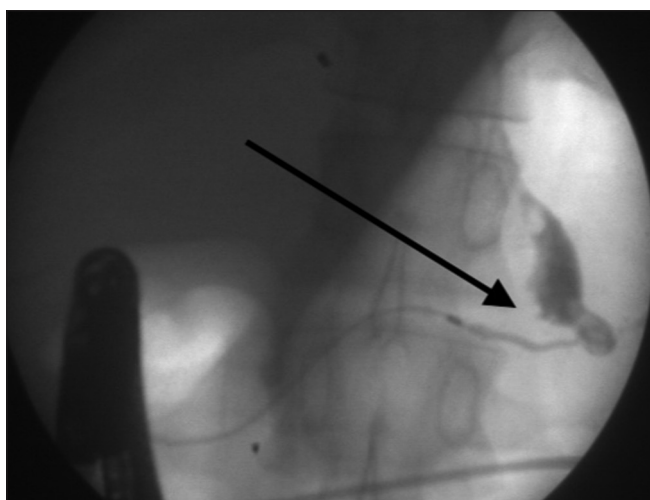
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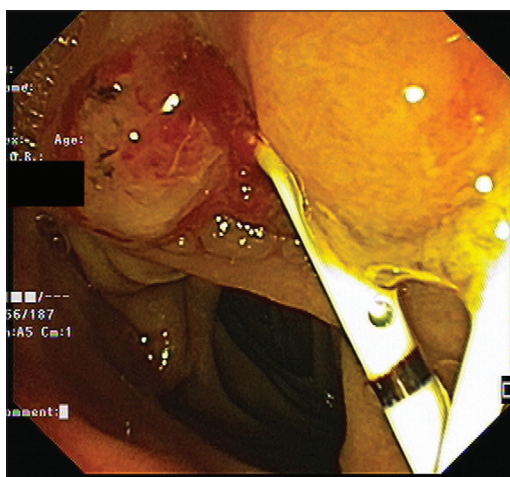
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**Figure 2.** (a) Papilla with precut sphincterotomy done; (b) EUS appearance of undilated pancreatic duct in the region of neck and proximal body of pancreas; (c) puncture taken into the undilated pancreatic duct with a 22G fine needle aspiration needle; (d) fluoroscopy showing contrast in the pancreatic duct with guide-wire passed across into the duodenum



**Figure 3.** Pancreatogram taken after rendezvous showing leak from the tail of the pancreas



**Figure 4.** 5 Fr plastic single pigtail stent placed across the minor papilla after sphincterotomy

pancreas. Pancreatogram showed leak from the tail of the pancreas [Figure 3]. After sphincterotomy, 5 Fr pancreatic stent placed across the leak in tail region [Figure 4]. Intercoastal drain output reduced

to nil by day 7 and was removed on day 10. He was discharged after nutritional rehabilitation on day 14 after procedure.

Endoscopic pancreatic stent placement remains the mainstay of therapy for symptomatic PD obstruction or leakage.<sup>[1]</sup> The first report of EUS-guided pancreatic access with RV was reported in 2002.<sup>[2]</sup> EUS RV is more challenging than transmural drainage due to difficulty passing guidewire across the papilla and exchange to a duodenoscope.<sup>[3]</sup> The technical success of antegrade pancreatic ductal interventions is 87%, including RV and antegrade stenting. Puncture in undilated duct is more challenging, with difficulty gaining access and passing guidewire across the papilla. Only one case report describes EUS RV in a patient with undilated PD and chronic pancreatitis with pancreatic ascites.<sup>[4]</sup> We were able to achieve access of the undilated PD in our patient with EUS guidance and subsequently bridge the pancreatic leak.

#### *Declaration of patient consent*

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal his identity, but anonymity cannot be guaranteed.

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Nil.

#### *Conflicts of interest*

There are no conflicts of interest.

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