LETTER TO THE EDITOR

Spontaneous Intra-Gastric Walled-Off Pancreatic Necrosis Rupture

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Dear Sir,

A seventy two-years old male presented with fever, abdominal discomfort and vomiting six weeks after an episode of gall stone acute pancreatitis. An i.v. contrast abdominal Ct scan revealed a cystic collection 6×7 cm with air level at the tail of pancreas bulging towards stomach. Lab exams revealed only leukocytosis. On gastroscopy a small fistulous opening was found at the posterior wall of upper stomach corpus. A pus like discharge from the opening was noted (Figure 1). Further, the fistulous opening was step-wise dilated so that the instrument tip carefully entered the cavity (Figure 2). The cavity was full of debris, semi-solid necrotic material and a greenish liquid. Culture sample and cytology were both negative. The debris was aspirated through the scope meticulously. Further, the cavity was thoroughly irrigated with sterile normal saline and a nasobiliary catheter was left inside to secure a continuous irrigation along with drainage. The patient was kept on nil by mouth, i.v. broad spectrum antibiotics and gradually recovered uneventfully. White blood cells returned to normal and an i.v. contrast CT scan two months later depicted no fluid collections.

Fortunately, the spontaneous rupture of this walled-off pancreatic necrosis in the stomach of our patient was both uneventful and therapeutic. Additional manipulations with suction and intra-cystic irrigation further contributed to our patient clinical improvement.

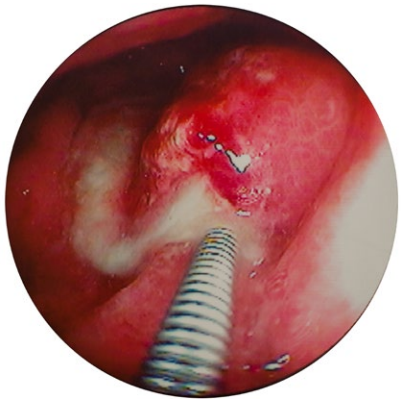

Figure 1. Intra-gastric fistula with pus exudate.

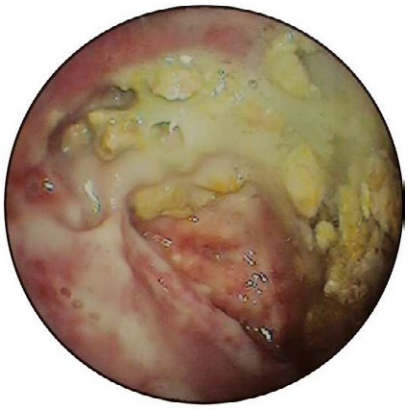

Figure 2. Walled-off pancreatic necrosis interior.

Walled-off pancreatic necrosis (WOPN) is a serious complication that may ensue at least four weeks after an episode of acute pancreatitis. According to the revised Atlanta classification, fluid collections that appear in the setting of pancreatic necrosis are further categorized as acute necrotic collections (ANC) or progressively to WOPN based on their maturity. Additionally, the revised Atlanta Classification recommends that the presence of any solid material or debris in pancreatic collections named as WOPN [1]. CT scan presents a moderate discriminate cut-off, only 45% to identify solid debris in WOPN [2]. The incidence of acute pancreatic fluid collections, in general, varies from 30 % to 50 % and most of them resolve spontaneously [3]. It is only symptoms or complications that necessitate intervention and not the size [3]. Cysts larger than 6 cm, protruding stomach wall can endoscopically be treated via cyst gastrostomy [4]. Endoscopic ultrasound, if available, can safely delineate confounding vasculature prior to any endoscopic intervention. The natural history of WOPN without any intervention is unknown. Spontaneous uncomplicated rupture of WOPN into stomach is very rare, less than 3% [5]. This favorable outcome is considered the rationale for endoscopic drainage of walled -off pancreatic fluid collections.

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Conflict of Interest

Authors declare to have no conflict of interest.

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