ORIGINAL RESEARCH PAPER

General Surgery

UNSUAL CASE OF PSEUDOCYST OF PANCREAS WITH COMPLICATION LEFT GASTRIC ARTERY RUPTURE PSEUDO ANEURYSM PRESENTATING AS ANEMIA IN CHRONIC PANCRETITS IN ALCOHOLIC PATIENT

KEY WORDS:

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INTRODUCTION

Case report a 24 years male patient name Mr.manoj Bhai dineshbhai parmar from ranip Ahmedabad Gujarat came to emergency department at civil hospital Ahmedabad on date 29/9/2020 with Chief complian of abdominal pain since +1day. patient was asymptomatic before 1day than he complin of pain in left side abdominal pain which is mild,dull aching non radiating .

patient has similar episode of pain 6month back for that pt was admitted civil hospital Ahmedabad no documents available. patient was chronic alcoholic stop since 1year.no significant family history.

General examination

- patient was severe anemic with pulse 86/min, Bp114/86tongue,lower conjunctiva show pallor.
- per abdominal examination -soft non tender ,no any palpble mass.

INVESTIGATION

- Ultrasound showed-multiple collections intrapancreatic and peripancreatic with pancreas appears atrophic in body region.approx 50*50*81mm sized thick walled collectio(Wall thickness4mm) without internal achoes is noted in region of head and proximal body of pancreas. anteriorly it abuts posterior wall of pylorus and posteriorly lesion abuts confluence of portal vein.Approx 69*74*69 mm sized collections is noted in relation to body of the pancreas and it shows heterogeneous areas witout internal vascularity within p/o collections with hematoma formation.Approx 44*82*70I'll defined collections is noted in relation to tail of pancreas anterior to splenic hilum.finding s/p/o Acute on chronic pancreatitis with collections.

Blood investigation

- On admission
- Hemoglobin---2.69gm/dl
- Wbc—5.4*10^3/cmm
- Rbc---1.79*10^6/cmm
- Hematocrit—10.40%
- Platelets----301.00*10^3/cmm

- Peripheral smear show-----RBC mass decreased ps shows microcytic moderate to severely hypochromic rbcs.wbc and platelets normal.mp not seen
- Bleeding time and clothing time –normal
- Sickling test ---negative
- Aptt and PT inr ---normal
- RFT was normal
- LFT was normal
- Urine examination—no present of pus cells and red blood cells
- S.amylase—49.15iu/l
- S.iron—131.10ug/d
- lS.ferritin—314.60ng/ml
- S.vitB12—139.00pg/ml
- G6PD activity---present
- D-dimer value---0.156ug/ml
- Reticulocytes count----4..%
- DCT---negativeIct---negative
- After 5 pcv transfusion patient hemoglobin on date 4/10/2020----7.7gm/dl with increse Rbc,, hematocritPatient diagnose as iron deficiency anemia after 7.7 hb.

Patients has started iron sucrose injection iv as per medical opinion.during in admited time no c/o hemetemesis and hematuria and blood in stool or abdominal pain . patient vitally also stable.

CECT abdomen –

- pelvic show(30/09/2020)Sequale to necrotizing pancreatitis.pseudocyst noted in uncinate process and head,body as well as tail region measuring 55*53*64mm in head and uncinate process,62*74*70 mm in body region and 78*44*66mm in tail region.mpd dilated in body and tail region --11mm communicating with collection.
- Largest cyst compression over second part of duodenum. common hepatic artery is adjacent to the wall of pseudocyst in the body region and gastro duodenal artery is adjacent to the wall of psedocyst in the body region and gastro duodenal artery is adjacent to the pseudocyst in the head region.There is small aneurysm measuring 7*9*8mm noted originating from left gastric artery in the superior wall of the collection in body of panceas.there is adjacent hyperdensity measuring 42*38*40 mm within the collection----most likely ruptured aneurysm..no evidence of active contrast extravagation. splenic vein is compressed , possiblity of partial occluded thrombus within.

- **Cardiologists** opinion for a cect finding suggestive of small aneurysm measure 7*9*8mm originating from left gastric artery in superior wall of collection in body pancreas with collection 42*38*40mm most likely ruptura aneurysm no evidence of active contrast extravagation. cardiologist opinion for this finding was kindly do cardio vascular opinion.
- Same reference for a left gastric artery aneurysm **CTVS DEPARTMENT . they advise interventional cardiologist opinion for Coiling or stenting.**

- On the next day 3/10/2020

- **interventional cardiologist** opinion taken for same finding they advice **review of CT abdominal vessels after two weeks** .patient was vitally stable and discharge on date 4/10/2020.

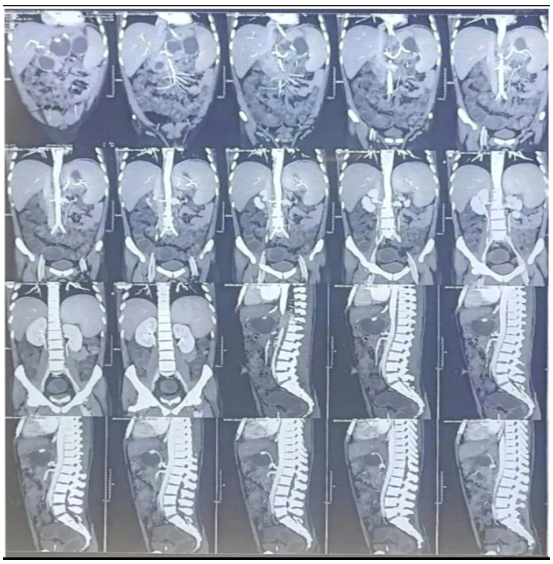
- Patient was re admitted on 8/10/2020

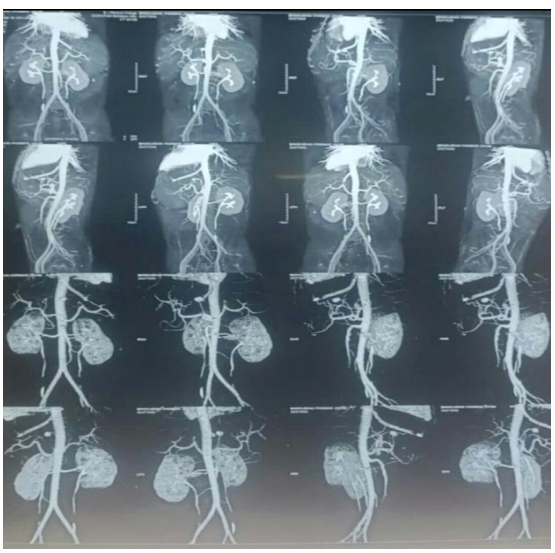
- c/o hematemesis episode 4 time in a day patient was keep NBM and **ultra sonography abdo pelvis** done on

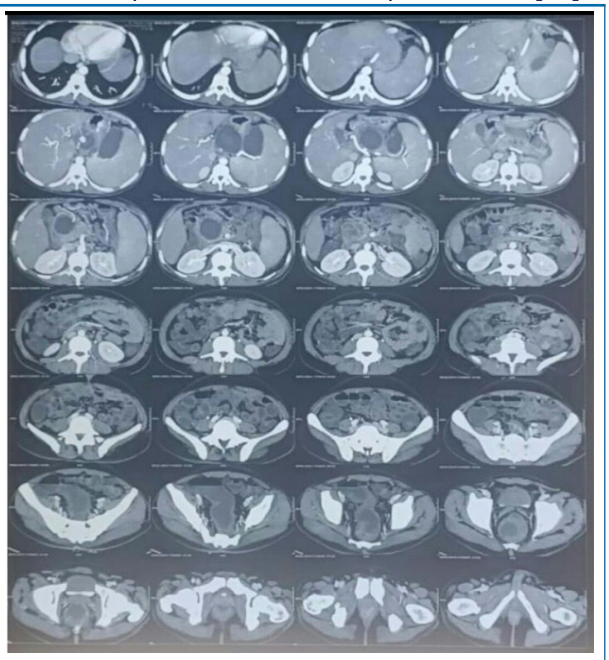
the same day suggestive of multiple intra pancreatic an peripancreatic collection approximately 36*49mm size with collection wall thickness 4mm without internal vascularity in the region of head proximal body of pancreas anteriorly it abrupt anterialy stomach wall and posteriorly it abrupt the posterior wall confluence of portal wall approx70*69*67mm size collection noted anterior region of body of pancreas approx 34* 35mm size hyperechoic lesion noted arise from **left gastric artery** it's approx 12*12mm size finding show partial thrombosis aneurysm approx 65* 58 * 57mm well defined collection noted in the relation to tail of pancreas anterior two splenic hilum these findings suggestive of acute and chronic pancreatitis with collection And bleeding from aneurysm.

CECTWITH ANGIOGRAPHY OF ABDOMEN

- suggestive of multiple collection in relation to head body and tail of pancreas approx 52*51*54mm size collection is noted in head of pancreas .medially it abrupt superior mesenteric vein and gastroduodenal artery .approx 72*65 *65 mm collection is noted in body or pancreas. antirely it related to body of stomach posteriorly abrupt superior mesenteric artery and splenic vessel .splenic vein appear compressed approx 17*15 * 5MM size secular dilatation arising from left gastric artery is noted along superior wall .it shows an approx 34*35*23mm size hyperdense Lesion is noted in relation to aneurysm suggestive of rupture aneurysm.







Cardiologists opinion

Than patient was transfer to UN maheta hospital Ahmedabad in interventional cardiology department on 13/10/2020 with provisional diagnosis of chronic alcoholic chronic pancreatitis and left gastric artery pseudo aneurysm in emergency Department for coiling of left gastric artery pseudo aneurysm. emergency embolization of left gastric artery done via right brachial artery three bear off helical coil use and pve particle355 micro push. patient is stable hemodynamically after the procedure .patient was discharged on the same day with oral antibiotic.patient was follow up on 21/10/2020 with no any fresh complain and his hemoglobin was 15mg/dl.no more episode of hemetemesis.

DISCUSSION

- Visceral artery aneurysms are divided into true or pseudoaneurysm.a true aneurysm involves all layers of the vessel wall and is created due to partial digestion of the arterial wall, destroying the elastic tissue of tunica media by the inflammatory process, whereas pseudo-aneurysms are false aneurysms which result from injury to one or more vessel wall layers.
- Pancreatic pseudoaneurusms are formed by the erosion of the pancreatic or peripancreatic artery into a pseudocyst. they are most common after pancreatitis,but they can also occur after pancreaticobiliary surgery, pancreatic transplantation, trauma, and motor vehicle accident.
- Pseudosneurysm was first reported by starlinger in 1930;since then,there has been an increasing number of reports on aneurysms due to improved radiological techniques.
- The pathophysiology of these aneurysms is not clearly understood; weakening of the vessel by leakage of proteolytic enzymes has been implicated in pathogenesis.
- Pseudoaneurysms are classified according to the artery they originate from, communication with the gastrointestinal tract, and exposure to pancreatic juice.
- The most commonly involved artery (30-50%)due to its proximity to the pancreas .after the splenic artery the gastroduodenal artery is involved in 10% and the pancreaticoduodenal artery in 10% and followed by the superior mesenteric,left gastric, hepatic,and small intrapancreatic arteries,
- In patients presenting with abdominal pain only it is difficult to distinguish pseudoaneurysm from a bout of acute pancreatitis, which usually presents with similar

symptoms.CT abdomen and pelvis with angiogram is gold standard for the diagnosis.

- Treatment modalities include either embolization (coils, coveres stent, percutaneous or transcatheter thrombin injection)or surgery. Endovascular therapy in terms of less postoperative pain,shorter hospital stay,and early return to activities od daily life.
- In the event of failed embolization or rebleeding after embolization surgery, either direct ligation of the bleeding vessel or resection of pancreas with pseudoaneurysm should be perfomed.early and lare complication is re-bleeding in 20-40% of patients.

CONCLUSION

- Pancreatic psedoaneurysm is a rare vascular complication of pancreatitis, resulting from erosion of the pancreatic or peripancreatic artery into a pseudocyst.
- However ,it may happen after pancreatic or gastric bypass surgery or trauma.
- It may lead to fatal complications if left untreated.
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