ORIGINAL RESEARCH PAPER

General Surgery

PANCREATIC PSEUDOCYST PRESENTING AS A RIGHT ILIAC FOSSA MASS: A CASE REPORT

KEY WORDS: Pancreas, Pseudocyst, Cystojejunostomy, Right Iliac Fossa Mass

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ABSTRACT

Pancreatic pseudocysts usually resolve spontaneously, but complications can develop, e.g., infection, rupture, pressure effects, pain, erosion into a vessel. Therapeutic intervention is advised only if the pseudocyst causes symptoms, complications develop and distinction to be made between pseudocyst and a tumor. Surgical drainage involves internal drainage into the cyst to the gastric, duodenal or jejunal lumen. Here we present a case of 36 year male patient with pain abdomen on and off since 2 months and lump in right iliac fossa since one month. CECT Abdomen showed pancreatic pseudocyst of size 13 x 8 cm extending up to Right Iliac Fossa and patient was surgically managed with Cystojejunostomy. This case illustrates the significance of considering pancreatic pseudocyst as a differential diagnosis in patients presenting with Right Iliac Fossa Mass.

INTRODUCTION

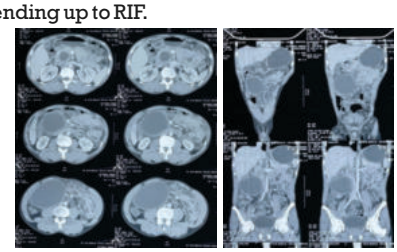
Pancreatic pseudocyst is a collection of amylase-rich fluid enclosed in a well-defined wall of fibrous or granulation tissue. It typically arises following an attack of mild acute pancreatitis and lies outside the pancreas. Formation of a pseudocyst requires 4 weeks or more from the onset of acute pancreatitis.

Here we present a case of pancreatic pseudocyst presenting as right iliac fossa mass.

Case Presentation

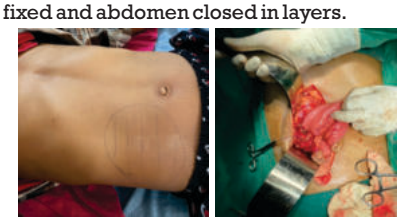
A 36-year-old patient presented at OPD with pain abdomen on and off for last 2 months and lump in RIF for last 1 month which gradually increased in size. He is a known alcoholic since 10 years. Physical examination revealed a non-tender, circular lump in RIF with diameter around 12 cm.

CECT Abdomen showed multiloculated peripherally enhancing thick-walled cystic lesion of size 13 x 8 cm in peripancreatic region adjacent to pancreatic head. Lesion is seen extending up to RIF.

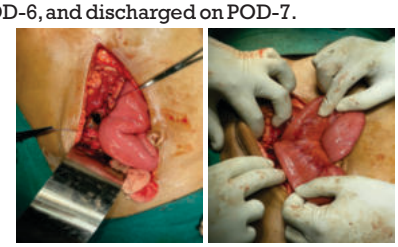


Treatment

- Patient was taken for surgical intervention under General Anesthesia.
- Midline incision given from xiphisternum to umbilicus. Multiloculated pancreatic pseudocyst identified and cyst fluid aspirated. Cystojejunostomy was performed 20 cm from the DJ (duodenojejunal) flexure with PDS 3-0. Pelvic drain fixed and abdomen closed in layers.



- Patient was started on liquid diet on POD-3, drain removed on POD-6, and discharged on POD-7.



DISSCUSSION

- Pancreatic pseudocysts occur in 5–15% of patients who have peripancreatic fluid collection after acute pancreatitis.
- By definition, the capsule of a pseudocyst is composed of collagen and granulation tissue, and it is not lined by epithelium. This fibrotic reaction typically requires at least 4–8 weeks to develop.
- The diagnosis is corroborated by CT or MRI. Characteristic features of pancreatic pseudocysts include high amylase levels associated with the absence of mucin and low carcinoembryogenic antigen (CEA) levels.
- Spontaneous regression has been documented in up to 70% of cases, particularly in patients with pseudocysts smaller than 6 cm, located in the tail and no evidence of pancreatic duct obstruction.
- Surgical drainage can be done with a cystogastrostomy or cysto-enterostomy depending on the location of the cyst.
- Modern evidence suggests that transgastric and transduodenal endoscopic drainages are safe and effective approaches for patients with pancreatic pseudocysts in close contact (<1 cm) with the stomach or duodenum.

The D'Egidio Classification of Pancreatic Pseudocysts and the Primary Treatment Options

Type	Content	Pancreatic Duct	Duct-Pseudocyst Communication	Primary Treatment
I	Acute pancreatitis	Normal	No	Percutaneous drainage
II	Acute-on-chronic pancreatitis	Abnormal (no stricture)	50:50	Internal drainage or resection

III	Chronic pancreatitis	Abnormal (stricture)	Yes	Internal drainage with duct de-compression

CONCLUSION

Though rarely, but pancreatic pseudocyst can sometimes present as Right Iliac Fossa mass. Correct diagnosis and surgical management is very promising to prevent complications.

Declration of Competing Interest

The authors declare no competing interest.

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