

Case Report

Hemosuccus Pancreaticus: A Rare Entity

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ABSTRACT

Hemosuccus pancreaticus, also named as Wirsungorrhagia or psuedohematobilia is a rare condition of intermittent hemorrhage from upper gastrointestinal tract. The source of bleeding is from a visceral aneurysm into main pancreatic duct in patients with chronic pancreatitis. It is a life threatening complication of pancreatitis and a significant diagnostic challenge due to its intermittent nature and rarity. This is a case of male patient with chronic pancreatitis presenting with hemosuccus pancreatitis from an aneurysm of splenic artery, treated successfully by distal pancreatectomy and splenectomy.

Key Words: Hemosuccus Pancreatitis Splenic artery aneurysm Splenectomy

INTRODUCTION

Hemosuccus pancreaticus is an unusual complication of pancreatitis with intermittent hemorrhage in upper gastrointestinal tract from a visceral aneurysm into the main pancreatic duct. The hemorrhage ranges from intermittent occult bleed up to severe bleeding causing death.

It was by Lower and Farrellin the year 1931, who first reported that the source of hemorrhage was from aneurysm of splenic artery into main pancreatic duct. [1] It is also called as Pseudohematobilia or Wirsungorrhagia. In 1970, Sandblom coined the term Hemosuccus pancreaticus. [2]

This condition is of diagnostic challenge due to its intermittent nature and rarity. This is one such case of Hemosuccus pancreaticus in a chronic pancreatitis patient with aneurysm of splenic artery as a source of bleeding.

CASE REPORT

A 42yr old male patient came with complaints of bouts of recurrent

hematemesis following a colicky abdominal pain since one year. He had severe anaemia for which five units of blood was transfused.

Upper gastrointestinal endoscopy reported oesophagitis and fundal gastritis for which he was treated conservatively. Colonoscopy reported normal.

Ultrasonological imaging showed chronic pancreatitis and was further evaluated with computed tomography which reported the same with pseudo pancreatic cyst at tail of pancreas (Figure 1) and aneurysm of splenic artery which was delineated on magnetic resonance angiogram (Figure 2).

The hematological report showed improvement in haemoglobin level (8gm%) after blood transfusion with low hematocrit value (24vol%). Liver and renal function tests were within normal limits.

Patient was operated, distal pancreatectomy with ligation of splenic artery aneurysm and splenectomy was done (Figure 3,4). A pseudocyst was seen at tail of pancreas (Figure 5) and splenic infarct

noted in splenectomy specimen (Figure 6). Postoperatively patient was stable, blood

was transfused to improve his haemoglobin.

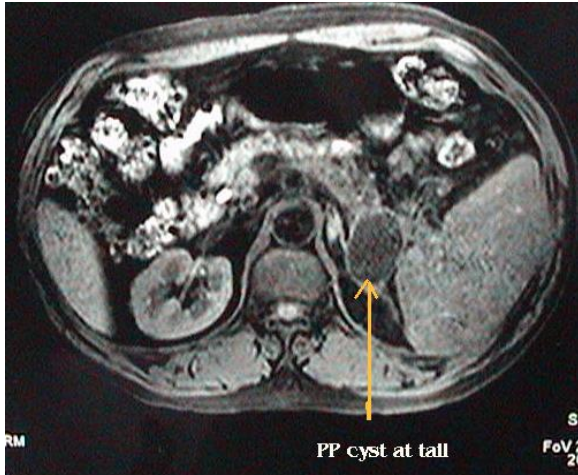


FIGURE 1: CT Abdomen



FIGURE 2: MR Angiogram

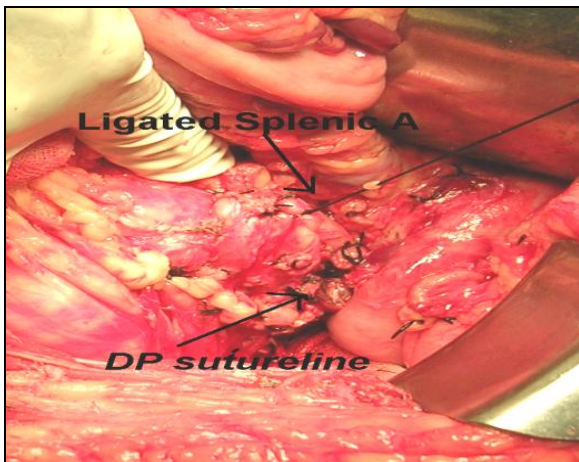


FIGURE 3: Surgery

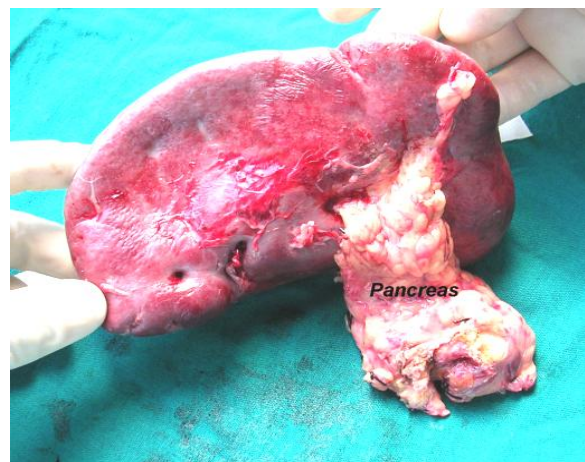


FIGURE 4: Spleen & Pancreas

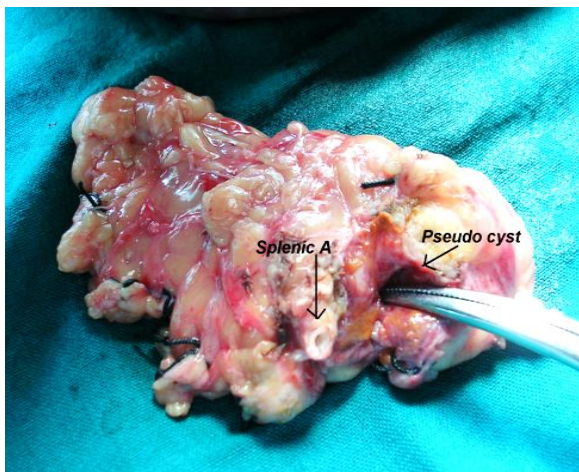


FIGURE 5: Pancreas



FIGURE 6: Spleen

DISCUSSION

Hemosuccus pancreaticus is a rare complication of pancreatitis presenting with intermittent upper gastrointestinal bleed

with symptoms of hematemesis, melena etc. The amount of bleeding ranges from mild to severe bleed which could be life threatening.

The pancreatic enzymes cause pseudoaneurysm formation of peripancreatic vessels. Chronic exposure of such vessels to these digestive enzymes creates a traction and communication with main pancreatic duct resulting in gastrointestinal hemorrhage. [3] The order of frequency of the vessel involved are the splenic (40%), gastroduodenal (30%), pancreaticoduodenal (20%), gastric (5%), and hepatic arteries (2%). [4]

A colicky abdominal pain precedes the bleeding. It has a crescendo-decrescendo course and is as a result of increased intraductal pressure due to blood in pancreatic duct or from ductal obstruction due to clot formation. [5]

It is an entity diagnosed with high suspicion on clinical, endoscopic and radiological imaging and definitive diagnosis established by angiography (MR angio superior to CT angio). [6]

Endoscopy rules out other causes of gastrointestinal bleed and can rarely identify blood exiting from ampulla of Vater. [7]

There are two therapeutic options: interventional radiographic procedures and surgery. The initial management method is with interventional radiographic procedures which include embolisation with prosthetic material like coil, balloon tamponade and stent placement.

Benzet al described for the first time successful implantation of an uncoated metal Palmaz stent across the aneurysmal segment of the splenic artery. [8] The recurrence rate of bleeding after angiographic embolization is around 30%. [9]

Surgical treatment is indicated when there is uncontrolled bleeding, persistent shock, failure of embolization, rebleeding after embolization. When initial angiography shows no abnormal findings, or when there is concomitant indication for operative intervention like pseudocyst, pancreatic abscess etc, the surgical procedure enables resection of diseased pancreatic and peripancreatic arterial tissue.

In this case surgical method is opted as there is concomitant pseudocyst to deal with at the tail of pancreas. Hence distal pancreatectomy with splenic aneurysm ligation and splenectomy was done.

Most surgical procedures have shown success rates of 70-85%, at the same time operative mortality rates of 10-50% have been reported in the literature. [10] The rate of rebleeding after surgery is around 0-5%. [9] In this case there was no bleeding after surgery.

Will et al reported for the first time a novel technique of EUS guided angiotherapy in treating hemosuccus pancreaticus. It can be an important diagnostic and therapeutic tool in selected candidates who do not have an angiographic evidence of bleeding, in whom contrast cannot be administered, or who are poor candidates for surgery. [11] However the safety and efficacy of such innovative techniques should be further evaluated.

CONCLUSION

Hemosuccus pancreaticus must be kept as a differential diagnosis in upper gastrointestinal bleed in case of chronic pancreatitis, and must be investigated with high suspicion. Endoscopy is the initial investigation and MR angiogram is the gold standard. Interventional radiographic procedure is the initial therapeutic procedure, but in case of unstable patients; failed embolisation procedure or any concomitant surgical procedure, surgery is the treatment of choice. In this case surgical method is opted as there is concomitant pseudocyst to deal with at tail of pancreas. Hence distal pancreatectomy with splenic aneurysm ligation and splenectomy was done.

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