Right-sided pancreaticopleural fistula

Larisa Vasilieva, Sofia Adamidi, Naso Kittou, Konstantinos Papiris, Andreas Romanos, Spyros P. Dourakis
Athens University Medical School; Hippokration Hospital, Athens, Greece

Pancreaticopleural fistula (PPF) is a rare complication of chronic pancreatitis due to communication of the pleural cavity (usually the left) with the pancreatic duct [1-5]. In contrast to fistulization, pleural effusion associated with acute pancreatitis is usually small, left-sided and described as either chemically-induced, sympathetic in nature, or due to the diffusion of pancreatic enzymes through diaphragmatic lymphatics.

We report the case of a 47-year-old alcoholic male with a history of chronic pancreatitis, who was admitted because of non-productive cough, dyspnea and orthopnea. Chest x-ray examination (Fig. 1A) and chest computed tomography (CT) revealed a large right pleural effusion (Fig. 1B) and flocing pancreatic calcifications. A chest drain was inserted and 3.8 L of exudative polymorphonuclear fluid with amylase 34455 U/mL were drained. Magnetic resonance cholangiopancreatography (MRCP) examination (Fig. 1C) showed chronic pancreatitis and PPF, and endoscopic retrograde cholangiopancreatography (ERCP) imaging revealed a pancreatic duct with characteristics of chronic pancreatitis and upper part communication with the pleural cavity (Fig. 1D). Initially, we performed pancreatic sphincterotomy. Guide wire catheterization with subsequent balloon cleansing produced secretions. Finally, after a pig tail stent was inserted and somatostatin was prescribed, the health of the patient improved. A second MRCP showed partial closure of the fistula (Fig. 1E) and undetectable amylase in the pleural effusion.

In conclusion, this case reminds us that PPF is associated rarely with right pleuritis and endoscopic treatment with somatostatin infusion can be effective.

References


© 2014 Hellenic Society of Gastroenterology www.annalsgastro.gr