



Clinical Image

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A Giant Bleeding Pancreatic Pseudocyst after a Blunt Traumatism in a Thirteen Year-Old Child

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Abstract

A thirteen-year-old boy presented with a grade IV blunt pancreatic traumatism with a cephaloisthmic disjunction. A giant pancreatic pseudocyst was developed and complicated with a massive intracystic bleeding. An evacuation and drainage of all collections was performed by laparotomy. Intracystic bleeding is rare but potentially lethal, CT/MRI and selective angiography lead to a better management. Surgical treatment may be confined to recurrent, multiple or > 200 mm pseudocysts.

Keywords

Pancreatic traumatism, Pancreatic pseudocyst, Intracystic bleeding, Chemical peritonitis

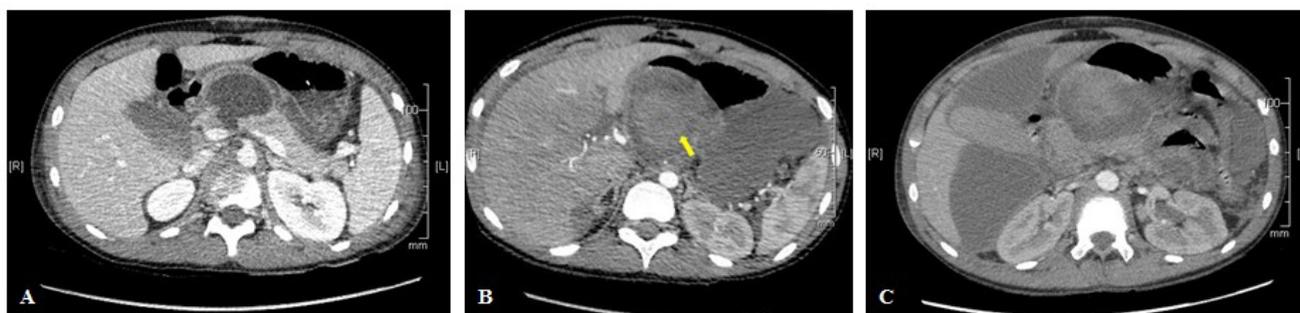


Figure 1A: CT scan at day 14 showing uncomplicated pseudocyst and the pancreatic trauma.

Figure 1B: CT scan demonstrating an active intracystic bleeding with a dramatic increased size.

Figure 1C: Multifocal peritonitis with sequestered pseudocyst, an old hematoma and hydro-hydric levels.

A thirteen-year-old boy presented with a grade IV blunt pancreatic traumatism with a cephaloisthmic disjunction secondary to an impact on his bicycle handlebar. As expected, he developed a pancreatic pseudocyst measuring 170 × 86 × 18 cm (Figure 1A: CT scan at day 14 showing uncomplicated pseudocyst and the pancreatic trauma). Whereas he was only slightly symptomatic, he presented at day 15 an acute and massive intracystic bleeding by erosion of the posterior pancreaticoduodenal artery (Figure 1B: CT scan demonstrating an active intracystic bleeding with a dramatic increased size). A radiological embolization of the proximal gastrodu-

odenal artery allowed hemodynamic stabilization of the patient. He secondary developed a compartmental syndrome of

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the abdomen with an active pancreatic leakage and chemical peritonitis (Figure 1C: multifocal peritonitis with sequestered pseudocyst, an old hematoma and hydro-hydric levels). The surgical evacuation and drainage of all the collections were performed by laparotomy. The pancreatitis and the ductal fistula eventually had a slow but favorable outcome.

Children pancreatic injury is the fourth solid organ injury in blunt abdominal trauma, following the spleen, liver and kidneys. Pseudocyst is a frequent complication. The presence of a ductal injury is a strong predictor of failure of nonoperative treatment [1]. However, severe injury of the pancreatic head can be managed expectantly, limiting drainage to symptomatic or > 50 mm pseudocysts [2]. Surgical treatment may be confined to recurrent, multiple or giant (> 200 mm) pseudo-

cysts [3]. Intracystic bleeding is rare but potentially lethal, CT/MRI and selective angiography lead to a better management.

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