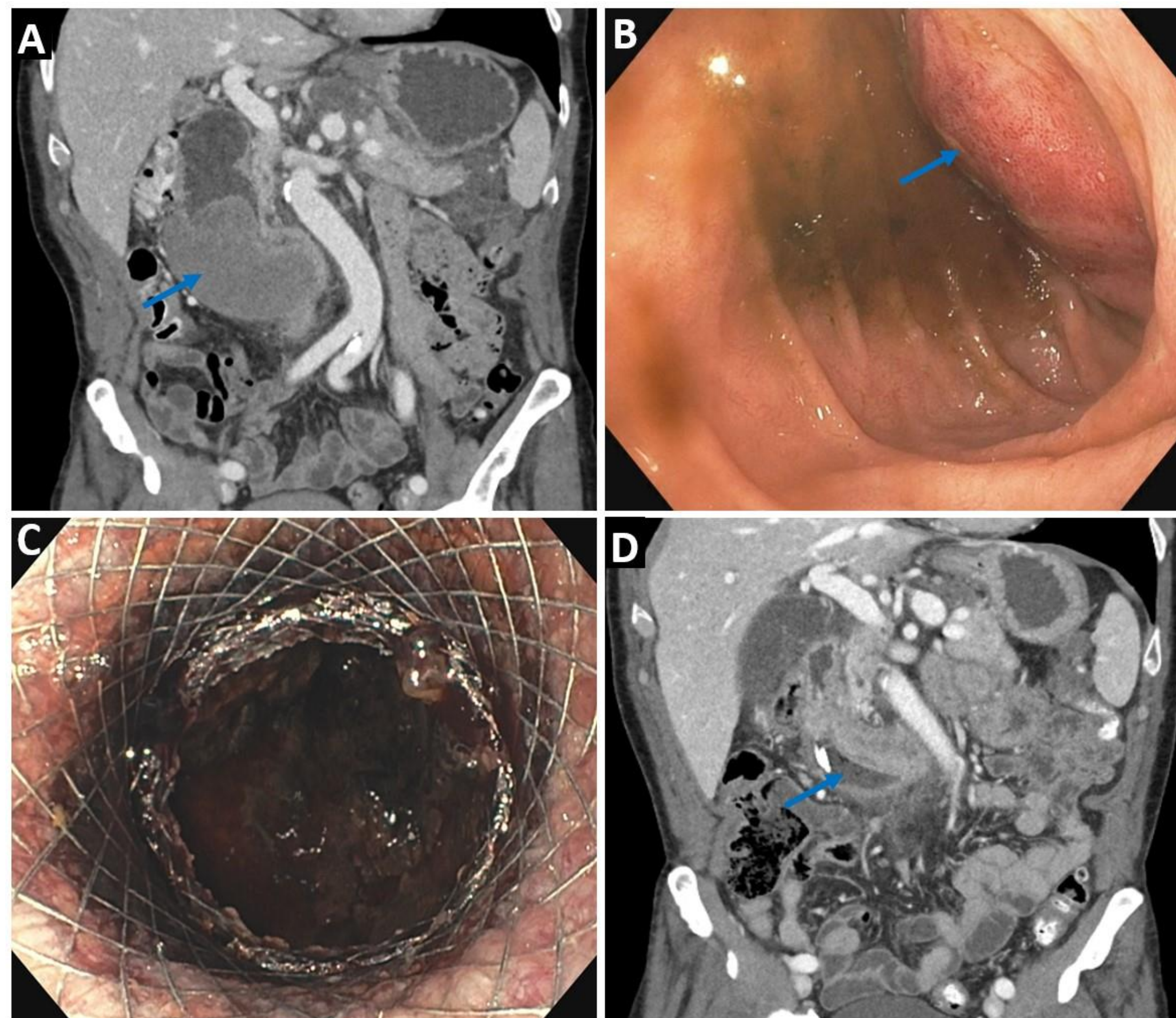


ENDOSCOPIC MANAGEMENT OF AN OBSTRUCTING DUODENAL WALL HEMATOMA IN THE SETTING OF ACUTE PANCREATITIS

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10 cm duodenal wall hematoma on CT scan (A) and endoscopy (B). Endoscopic drainage via cystoduodenostomy with a lumen-apposing metal stent (C). Resolution of the duodenal wall hematoma (D).

INTRODUCTION

Spontaneous duodenal wall hematoma is a rare condition which can be associated with acute and chronic pancreatitis. It is often complicated by small bowel obstruction. When conservative management fails, options are limited. Here we present a case of small bowel obstruction secondary to pancreatitis-associated duodenal wall hematoma which was successfully managed endoscopically through cystoduodenostomy.

CASE PRESENTATION

A 69-year-old male with HIV and normal CD4 count presented with acute abdominal pain and non-bloody emesis with lipase of 374 U/L (ULN 82). Computed tomography revealed acute pancreatitis and a 10 cm circumferential mass within the duodenum causing luminal obstruction (A). Endoscopic ultrasound confirmed a homogenous, hypoechoic subepithelial hematoma obstructing the second portion of the duodenum (B). A nasogastric-jejunal tube was placed for feeding and decompression.

ENDOSCOPIC MANAGEMENT

Due to persistent obstruction and IVC compression, on hospital day 10 endoscopic drainage of the duodenal hematoma was performed via cystoduodenostomy with a 15x10 mm electrocautery-enhanced lumen-apposing metal stent (LAMS) (AXIOS™, Boston Scientific, Marlborough, MA, USA) (C). The LAMS was immediately removed after near-complete evacuation of the hematoma cavity to minimize the risk of bleeding complications. A plastic double-pigtail stent was left in place to facilitate complete drainage. The duodenum was then dilated with a 12-13.5-15mm hydrostatic balloon dilator. The pigtail stent was removed 3 days later with clinical, radiographic, and endoscopic resolution of the duodenal obstruction (D).

DISCUSSION

Duodenal hematoma is a previously described rare complication of pancreatitis. Endoscopic evacuation was safe and effective in this patient. This minimally invasive option resulted in immediate resolution and can be considered when conservative management fails.

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