

Beware the succubus

Sean Lee MD, Michael Gavin MD

Introduction

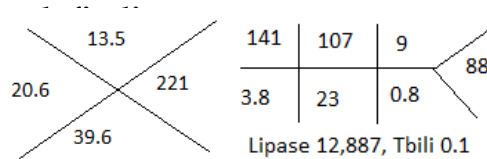
While most cases of acute pancreatitis resolve without issue, roughly 20% are considered moderately severe and associated with local complications (e.g. pseudocysts, necrotic collections), organ failure, or systemic complications such as exacerbation of comorbidities. (1) We present an interesting case of acute pancreatitis complicated by necrosis, portal vein thrombosis, and hemosuccus pancreaticus.

History

55M with chronic alcohol use presented to the emergency room with epigastric pain radiating to the back, vomiting, and decreased colostomy output for one day.

Physical exam

156/78, 87, 37.6, 14, 96% RA
 General: uncomfortable
 HEENT: normocephalic, PERRL, no lymphadenopathy, no thyromegaly. Moist membranes
 CV: S1S2, RRR, no m/r/g
 Lung: clear bilaterally
 GI: soft, TTP at epigastrium. No rebound. BS present. Colostomy with brown stool



Endoscopy

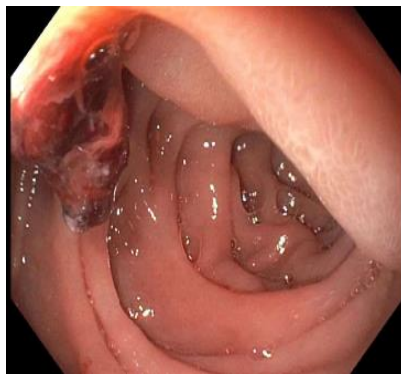


Figure 1: Endoscopy: blood clot protruding from ampulla

Patient course

CT abdomen revealed pancreatic fat stranding, peripancreatic head fluid collection, and a portal vein thrombus. Heparin drip was initiated. On hospital day 4, while awaiting MRI abdomen to further evaluate the fluid collection, the patient developed maroon stools and frank clots in the colostomy bag, eventually requiring transfusion of 2 units of RBCs. The MRI clarified the fluid collection as a 3.1 cm necrotic fluid collection filled with debris, fluid, and hemorrhage. An emergent EGD revealed a blood clot protruding from the ampulla (Figure 1). Imaging and endoscopic findings supported the diagnosis of hemosuccus pancreaticus. On visceral angiography, interventional radiology reported an eroded gastroduodenal artery which was embolized with coils. The patient required no further intervention to address the GI bleeding.

Discussion

Hemosuccus pancreaticus is the least common cause of upper GI bleed, estimated at 1/1500 cases, which translates to difficult or delayed diagnosis, and high mortality rates (overall estimated at 9.6%; 90% if untreated), owing to its risk of exsanguination. (2) It is defined as arterial bleeding into the pancreatic duct. Diagnostic work-up with imaging such as CT angiography or MRCP should be pursued in patients with pancreatitis, pancreatic pseudocysts or tumors, who present with gastrointestinal bleeding. Endoscopy may reveal bleeding or clots at the ampulla, and should be done to rule out other causes. Treatment often involves visceral angiography, though may require pancreaticoduodenectomy in severe cases.

References

1. Banks PA, Bollen TL, Dervenis C, Gooszen HG, Johnson CD, Sarr MG, Tsiotos GG, Vege SS, Acute Pancreatitis Classification Working Group. Classification of acute pancreatitis--2012: revision of the Atlanta classification and definitions by international consensus. *Gut*. 2013 Jan;62(1):102-11. doi: 10.1136/gutjnl-2012-302779. Epub 2012 Dec 25. PMID: 23100216.
2. Yu P, Gong J. Hemosuccus pancreaticus: A mini-review. *Arch Med Surg (Lond)*. 2018;28:45-48. Published 2018 Mar 9. doi:10.1016/j.amsu.2018.03.002