Incidental Pancreatic Pseudoaneurysm Following ERCP

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Introduction

- Around 500,000 ERCPs performed annually in the United States
- Common complications include infection, pancreatitis, hemorrhage and perforation

Case Presentation

- An 84-year-old female presented with one week of vomiting, epigastric pain and weakness after undergoing ERCP with stone removal and stent placement
- On presentation, the patient was hemodynamically stable
- Hepatic and pancreatic enzymes were within range, hemoglobin and hematocrit were stable, 12.6g/dL and 37.1%, respectively, and near patient's baseline (13g/dL)
- CT Abdomen with IV contrast showed a 9mm hyperattenuating PDA in/adjacent to pancreatic head (which was new from recent MRCP)

Case Presentation (contd.)

- Subsequent CT angiogram with pancreatic protocol redemonstrated stable 9mm PDA (Figure 1)
- Given no evidence of bleeding and improved clinical condition of the patient with supportive measures, no intervention was indicated, and the patient was discharged home

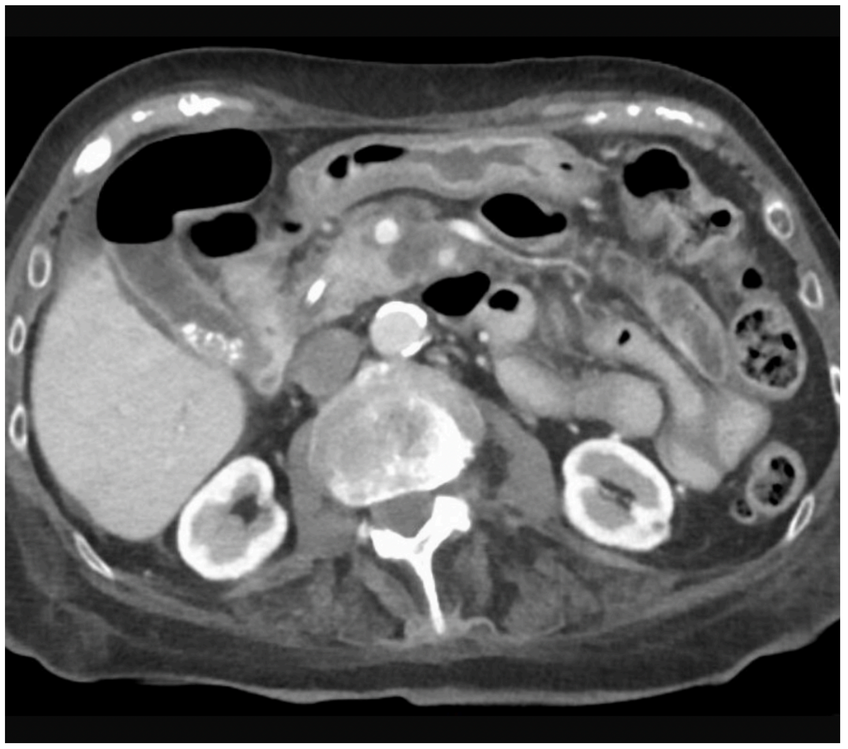

Fig 1. A 9mm focus of enhancement at the region of pancreatic head concerning for pseudoaneurysm.

Discussion

- Post-ERCP pancreatitis has an annual incidence of around 14%
- Post-procedure pancreatic PDA is rare, and seen in around 10% of the patients with post-ERCP pancreatitis
- Irritation of arterial and ductal walls by indwelling catheter can lead to the development of both pancreatitis and PDA
- Most of the previously reported cases of post-ERCP PDA were seen in sickle cell disease patients [1, 2]
- Our patient is unique as neither she had sickle cell disease, nor pancreatitis on arrival as per revised Atlanta criteria
- We suspect the patient developed pancreatitis prior to arrival to ED as she was symptomatic for one week after ERCP
- A bleeding PDA is an emergency with high morbidity and mortality, so prompt diagnosis and treatment is imperative to prevent further complications