DOI: 10.14260/jemds/2014/3364

CASE REPORT

UNUSUAL PRESENTATION OF PSEUDOCYST OF PANCREAS

N. Jayaraj[1], Lenin Baburajan[2], Justin Stephen[3], Linimol Hassan[4]

HOW TO CITE THIS ARTICLE:
N. Jayaraj, Lenin Baburajan, Justin Stephen, Linimol Hassan. "Unusual Presentation of Pseudocyst of Pancreas". Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 42, September 08; Page: 10469-10471, DOI: 10.14260/jemds/2014/3364

ABSTRACT: Pseudo cyst is a collection of amylase rich fluid enclosed in a wall of granulation or fibrous tissue in the lesser sac. Pseudo cyst is unilocular and has no epithelial lining. Pseudo cyst typically arises following an attack of acute pancreatitis, but can develop in patients with chronic pancreatitis (25%) or after pancreatic trauma. Pseudo cyst is more commonly seen in males, between the age of 30-40 years, Alcohol abuse is the major risk factor for the development of pseudo cyst. Reported here is a case of pseudo cyst of pancreas in a 51 year old male patient.
KEYWORDS: Pseudo cyst, amylase rich fluid, unilocular, no epithelial lining.

INTODUCTION: Pseudo cyst account for 90% of all cystic collections associated with pancreas. Pseudo cysts are more commonly seen in males between the age group 30-40 years. It is followed by an attack of acute or chronic pancreatitis and are most common in alcoholic chronic pancreatitis. This unilocular cyst is a collection of amylase rich fluid enclosed in a wall of granulation or fibrous tissue. Communication between cyst and pancreatic duct are seen in 70% of cases. In this article, a case is reported of a pseudo cyst of pancreas in a 51 year old male. This article seeks to highlight the diagnostic dilemma posed by the present case due to its atypical presentation.

CASE SUMMARY: 51 year old male patient, chronic alcoholic and chronic smoker presented with hiccup, chest heaviness and nausea for the past 2 weeks. Patient had a history of cysto gastrostomy done for pseudo cyst of pancreas 10 year back. No significant medical or family history.

On respiratory system examination there is reduced vocal fremitus dull note in percussion reduced vocal resonance and breath sounds in the left lower zone of chest. Other systems are within normal limits. Routine blood investigations, LFT, RFT, serum amylase, GGT, and TSH do not give any diagnostic clue. Chest x-ray shows n air – fluid level in the left lower zone chest. A provisional diagnosis of left hydro pneumothorax was made.

The diagnosis of pseudo cyst of pancreas is made through USG abdomen & confirmed by CT scan. CT showed – A large cyst measuring 13x12x11 cm is seen in the left side which appears to be arising from the region of the tail of pancreas. The fluid within the cyst is homogenous with air fluid level. Cyst wall is well defined smooth and shows areas of calcification.

Patient underwent exploratory laparotomy. During the surgery we could not find out the cystic mass. But there was a retroperitoneal fullness near the lesser curvature of stomach. Needle aspiration through this area did not give any fluid.

But aspiration through this area did not give any fluid. But aspiration through the stomach gave pus. To approach the collection, gastrostomy was done, which gave about 100 ml of pus in the stomach. This might be because of rupture of cyst into the stomach just before operation. Gastrostomy was put to drain the pus. This patient had an uneventful post-operative period. Patient was recovered from the illness.

DOI: 10.14260/jemds/2014/3364

DISCUSSION: Pseudo cyst account for 90% of all cystic collections associated with the pancreas. Pseudo cysts are more commonly seen in males between the age group 30-40 years. It is followed by an attack of acute or chronic pancreatitis and are most common in alcoholic chronic pancreatitis. This unilocular cyst is a collection of amylase rich fluid enclosed in a wall of granulation or fibrous tissue) communication between cyst and pancreatic duct are seen in 70% of cases

The most common symptoms associated with pseudo cyst is abdominal pain in 70% to 90% of Patients. Less common manifestations are a palpable mass, nausea and vomiting, jaundice and bleeding. Number of cystic collections can mimic the appearance of a pseudocyst, in particular. Cystic neoplasms (Mucinous, cyst adenoma, serous, cyst adenoma, papillary cystic neoplasms etc.).

Elevations in serum lipase or amylase can be a due to the presence of a pseudo cyst. The diagnosis of pseudo cyst is generally easily made through imaging studies, including ultrasonography, CT, MRI and EUS. The advantage of CT in this setting is visualization of the pseudo cyst's capsule, which can be used to gauge the maturity of the collection. ERCP is usually not required for diagnostic purpose, even though around 70% of pseudo cysts communicate with pancreatic duct.

Usually pseudo cyst will resolve spontaneously in most instances but complications can develop, like infection, rupture into gut, peritonitis, obstructive jaundice, pain or erosion into a vessel.

Therapeutic interventions are advised in symptomatic, complicated or enlarging pseudo cyst.

Therapy can be surgical, percutaneous, or endoscopic. Surgical therapy has been used most extensively and usually involves cyst decompression into a loop of small bowel or stomach, often coupled with a pancreatic ductal drainage procedure.

Pseudo cyst recurs only in about 10% of cases, pain may return in up to one half with long term follow up.

CONCLUSION: We have reported a case, which presented with hiccup and chest heaviness (Since 2 weeks) in a 51 year old chronic alcoholic and chronic smoker patient. A provisional diagnosis of left sided hydro pneumothorax was made. USG abdomen and CT scan shows large cystic mass measuring 13x 12x11 cm is seen in the left side which appears to be arising from the region of the tail of pancreas. Based on the imaging studies, a diagnosis of pseudo cyst of pancreas was made.

REFERENCES:

1. Cohn JA, Bornstein JD, Jowell PS: Cystic fibrosis mutations and genetic predispositions to idiopathic chronic pancreatitis. Med Clin North Am 84:621, 2000.
2. Whitecomb DC: Genetic Predispositions to alchoholic chronic pancreatitis 27:321, 2003
3. Layer P, Yamamoto H, Kalthoff L, et al: The different courses of early-and late-onset idiopathic and alcoholic chronic PANCREATITIS, Gastroenterology 107:1481, 1994
4. Ammann RW, Akovbiantz A, Largiarder F, et al: Course and Outcome of chronic pancreatisis. Gastroentrology 86:820, 1984
5. Schneider A, Whitecomb DC: Heriditary pancretitis: A model for inflammatory diseases of the pancreas. Best Pract Res Clin Gastroenterol 16:347, 2002
6. Witt H, Luck W, Hennies HC, et al: Mutations in the gene encoding the serine protease inhibitor, Kazal type 1 are associated with chronic pancreatitis. Nat Genet 25:213, 2000
7. Beger, H.G Warshaw, A. N, Buchler, M.W, Carr-locke, D. L, Neoptolemos, J. P, Russel, R.C.G & Sarr, M.G/ the Pancreas. Black well science, oxford.

DOI: 10.14260/jemds/2014/3364

8. Johnson, C.D. and Imrie, C.W. Pancreatic Disease. Towards the year 2000. Springer, London.
9. Trede, M. and D.C Surgery of the Pancreas. Churchill Livingstone, Edinburgh.
10. Jenkins, M.P, Alvaranga, J.C. and Thomas, J. M. The management of pancreatic disorder.

AUTHORS:

1. N. Jayaraj
2. Lenin Baburajan
3. Justin Stephen
4. Linimol Hassan

PARTICULARS OF CONTRIBUTORS:

1. Professor, Department of Surgery, Azeezia Medical College, Kollam.
2. Assistant Professor, Department of Surgery, Azeezia Medical College, Kollam.
3. Assistant Professor, Department of Surgery, Azeezia Medical College, Kollam.
4. House Surgeon, Department of Surgery, Azeezia Medical College, Kollam.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. N. Jayaraj,
Professor,
Department of Surgery,
Azeezia Medical College, Kollam.
Email: njayaraj1952@gmail.com

Date of Submission: 25/08/2014.
Date of Peer Review: 26/08/2014.
Date of Acceptance: 03/09/2014.
Date of Publishing: 06/09/2014.