Clinical Clip

PANCREATIC PSEUDOCYST DRAINAGE

Study courtesy of:
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HISTORY

A 44 year old female presented with persistent upper abdominal pain, vomiting and weight loss. CT identified a 6cm cystic mass. ERCP showed no ductal communication. EUS-guided aspiration revealed high amylase content, normal CEA and acellular cytology. Endoscopic cystogastrostomy was performed.

PROCEDURE

Cyst drainage was achieved using the Wilson-Cook **Cystotome**™ device and a linear EUS scope with a 3.8mm working channel. The bulging cyst was identified on EUS and an appropriate, avascular puncture site selected with the aid of Doppler (See Figure 1). The cyst was entered with the 5Fr needle knife of the Cystotome using cutting diathermy and puncture confirmed on EUS.

The 5Fr needle knife was replaced with a super-stiff guide wire and the puncture site enlarged with the 10Fr outer sheath using blend diathermy (See Figure 2).

The Cystotome was exchanged over the wire for a 10mm balloon dilator. Following deflation of the balloon there is often a large quantity of fluid released into the stomach (See Figure 3).

Two 7Fr, 4cm pigtail stents were then placed into the cyst completing drainage (See Figure 4). For infected cysts, a nasobiliary catheter can beplaced in the cyst and lavage instituted.

OUTCOME

In this case, EUS-guided drainage with the Cystotome resulted in complete resolution of the cyst. This was confirmed on follow-up EUS 6 weeks later, at which time the stents were removed.

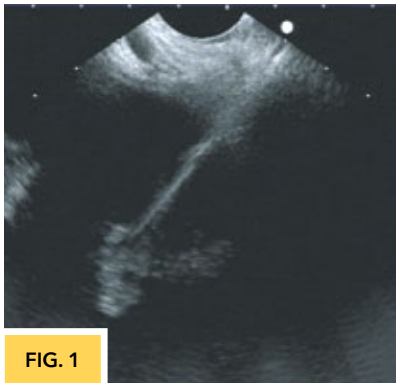

FIG. 1

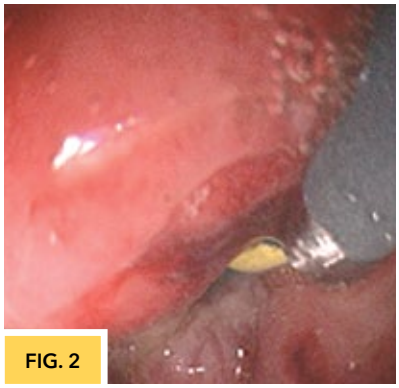

FIG. 2

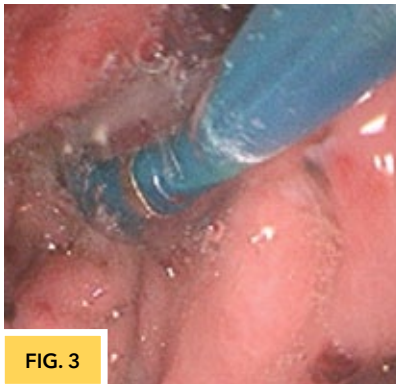

FIG. 3

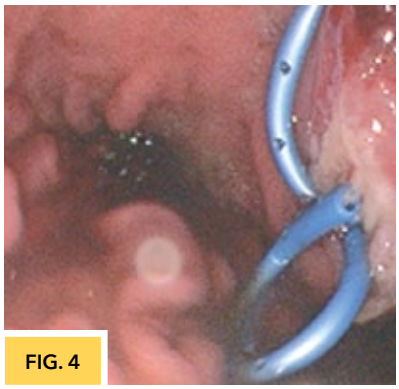

FIG. 4

COOK ENDOSCOPY
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