

Surgical Salvage of Partial Pancreatic Allograft Thrombosis Presenting as Ruptured Pancreatic Cyst: A Case Report

V.T.-W. Lee^{a,b,*}, H.-Y. Tiong^a, A. Vathsala^a, and K. Madhavan^a

^aNational University Hospital and ^bSingapore General Hospital, Singapore

ABSTRACT

Introduction. Vascular thrombosis is an important cause of pancreatic graft loss, and the vast majority is managed using graft pancreatectomy. There are limited reports and case series of successful salvage of the pancreas allograft. We describe a case of partial pancreatic allograft thrombosis presenting as ruptured pancreatic cyst successfully salvaged using a graft distal pancreatectomy.

Methods. We used descriptive retrospective analysis.

Results. A 29-year-old patient with type 1 diabetes and end-stage renal failure underwent a simultaneous pancreas kidney transplantation with immediate graft function. The cadaveric pancreas allograft was placed head up in the right iliac fossa with enteric exocrine drainage and standard vascular anastomosis. He presented with compressive symptoms on his bladder 5 months later, and a computed tomography (CT) showed a 4-cm cystic lesion in the body and tail of the pancreas allograft. Spontaneous rupture of the cyst occurred 3 weeks after the initial onset of symptoms with generalized abdominal pain. He underwent graft distal pancreatectomy with good recovery. He remains euglycemic, insulin-free with a normal renal function. Histology of the resected unhealthy graft showed an arterial thrombus with xanthogranulomatous inflammation and necrosis.

Conclusion. Surgical salvage with graft distal pancreatectomy is feasible for partial pancreatic allograft thrombosis. Cystic lesion in the pancreas is a possible presentation of vascular thrombosis.

VASCULAR thrombosis remains a leading cause of pancreatic allograft loss after pancreas transplantation. The vast majority of patients are managed by urgent graft pancreatectomy once vascular thrombosis is confirmed. There are limited reports and case series of successful surgical salvage of the pancreatic allograft [1–4]. In this report, we describe successful surgical salvage of partial allograft thrombosis using graft distal pancreatectomy. This case is unusual because our patient presented with a pancreatic cyst, which eventually ruptured, necessitating an urgent laparotomy. To the best of our knowledge, there are no published reports of partial pancreatic allograft thrombosis presenting as pancreatic cyst.

CASE REPORT

A 29-year-old Chinese male insulin-dependent diabetic with end-stage renal failure underwent simultaneous pancreas kidney transplantation. He was on peritoneal dialysis for 18 months prior to his

transplantation, and has been on insulin for 15 years. The pancreas and kidney allograft were from a 47-year-old ABO-compatible cadaveric donor. The pancreas allograft was procured with low-volume (3 L) histidine-tryptophan-ketoglutarate (HTK) aortic-only flush and preserved with HTK solution. Back-table preparation included donor splenectomy and reconstruction of the donor superior mesenteric and splenic arteries with a donor iliac artery “Y-graft.” The donor pancreas was of good quality and perfused well with no lesions. The arterial anastomosis was performed with a donor iliac artery “Y-graft” to the common iliac

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*Address correspondence to Victor Tswen-Wen Lee, National University Centre for Organ Transplantation, National University Hospital Singapore, NUHS Tower Block Level 8, 1E Kent Ridge Road, Singapore 119228. E-mail: surrtw@nus.edu.sg

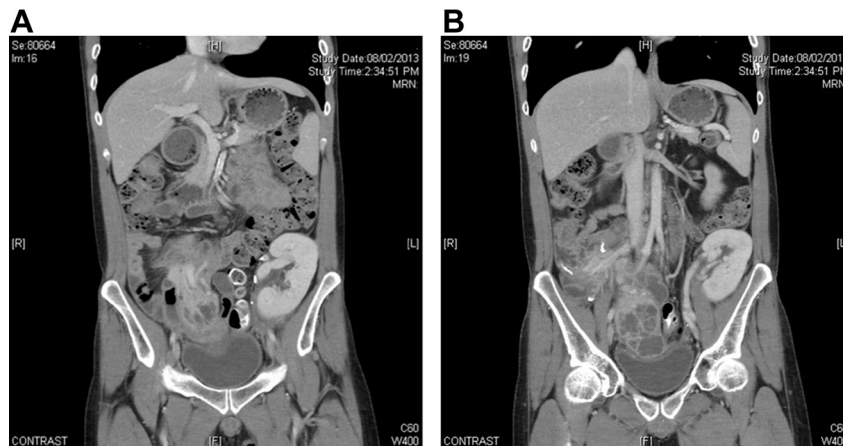


Fig 1. (A and B) A 4-cm cystic lesion in the body and tail of the pancreas with intact splenic artery on CT evaluation (5 months after transplantation).

artery and portal drainage was to the inferior vena cava. The cold ischemia time was 9.5 hours, and the graft reperused well with immediate function. The renal graft had a cold ischemia time of 7 hours and had immediate graft function. Graft duodenoenterostomy was performed with a 2-layer hand-sewn technique, with the pancreas graft in the right abdomen and placed head up. The renal graft was placed in the left iliac fossa in the extraperitoneal space.

Induction immunosuppression consisted of rabbit antithymocyte globulin (thymoglobulin) 1 mg/kg/dose for 5 doses. Maintenance immunosuppression consisted of tacrolimus, mycophenolate mofetil, and prednisone. Prophylactic anticoagulation therapy with enoxaparin was commenced immediately after surgery, and continued for 1 month. Low-dose aspirin of 100 mg daily was administered and continued long-term. In the immediate postoperative course, the blood sugar levels normalized and the patient remained insulin-free throughout.

His postoperative recovery was complicated by prolonged ileus and gastroparesis, requiring a week of parenteral nutrition. He was eventually discharged well after 4 weeks. He required 2 hospital admissions on the second and third month postoperatively for intra-abdominal collection, perinephric graft collection, and urinary sepsis, which resolved with percutaneous drainage and intravenous

antibiotics. Renal biopsy on the third month did not show any evidence of rejection. Serum amylase and blood sugar levels have remained normal with no evidence of pancreatitis.

Five months after the transplantation, he complained of compressive symptoms on his bladder, which were relieved after he emptied his bladder. A computed tomography (CT) scan showed a 4-cm cystic lesion at the body and tail of the pancreas allograft (Fig 1A and 1B). The serum amylase level was normal. The serum creatinine level was slightly elevated at 140 mmol/L. Renal biopsy did not show any evidence of rejection. The CT scan did show a small thrombus at the distal superior mesenteric artery but did not show any splenic artery thrombus. We elected to observe this cystic lesion closely because his symptoms were not too worrisome.

He presented 3 weeks later to the emergency department with sudden abdominal pain and diarrhea. The serum amylase and lipase levels remained normal. He had low-grade fever and was started on intravenous antibiotics. On examination, his temperature was 38°C, and there was generalized abdominal tenderness. The blood sugar level was normal, white blood cell count was 7800/ μ L, and the C-reactive protein was 108. A CT scan showed generalized fluid collection in the abdomen, and a partially decompressed pancreatic

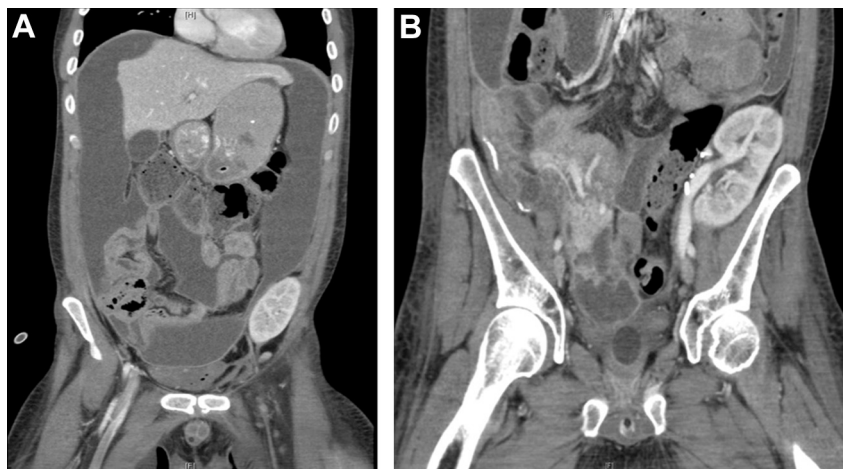


Fig 2. (A and B) CT with ruptured pancreatic cyst and generalized fluid collection.

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