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Successful treatment for severe pancreatitis with colonic perforation using video-assisted retroperitoneal debridement: A case report

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ABSTRACT

INTRODUCTION: Colorectal complications including penetration and perforation in acute pancreatitis often become severe and fatal. Effective drainage is pivotal for successful treatment. We present a case of large retroperitoneal abscess with colonic necrotizing perforation due to severe acute pancreatitis treated with video-assisted retroperitoneal debridement (VARD) in a step-up approach.

PRESENTATION OF CASE: A 31-year-old man was admitted to a general hospital with a diagnosis of severe acute pancreatitis. Ten days after onset, he was referred to our hospital for more intensive treatment. On day 16, he experienced melena and shock, and embolization of the three straight arteries of the descending colon was performed. On day 30, percutaneous drainage was performed for large retroperitoneal abscess. On day 36, ileostomy was performed because the drained pus from the retroperitoneal abscess became feces-like. On day 58, VARD was performed to treat the refractory retroperitoneal abscesses causing high systemic inflammation due to insufficient drainage. On day 85, fluoroscopic examination showed disappearance of the abscess cavity. He was transferred to the previous hospital on day 89.

DISCUSSION: Colonic perforation due to severe acute pancreatitis often causes sepsis and fatal condition of patients, and drainage of the retroperitoneal abscesses via laparotomy is thought to be highly invasive and risky. VARD enables radical necrosectomy and drainage less invasively.

CONCLUSIONS: VARD enabled less invasive treatment for patients with large retroperitoneal abscess due to colonic necrotizing perforation in severe pancreatitis.

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1. Introduction

Treatment for severe acute pancreatitis with colonic perforation is difficult and the mortality is high [1–3]. In most of previous reports, colon resection and ileostomy/colostomy were performed simultaneously. However, these procedures are highly invasive and likely to cause refractory wound infection in patients with marked intra-abdominal adhesions and large abscesses. We present a case of severe acute pancreatitis with large retroperitoneal abscess due to colonic necrotizing perforation treated by video-assisted retroperitoneal debridement (VARD) in a step-up approach. This case report has been reported in line with the SCARE criteria [4].

2. Presentation of case

A 31-year-old man was admitted to a general hospital with the diagnosis of severe acute pancreatitis due to fallen gallstones. Pancreatic and biliary stents were placed by emergency endoscopic retrograde cholangiopancreatography. Ten days after onset, he was referred to our hospital for more intensive treatment because his general condition deteriorated. Blood pressure on admission was 155/100 mmHg, heart rate was 120 bpm, body temperature was 38.2 °C, and SpO₂ was 100% (nasal high flow, 40 L/min; FiO₂, 0.5). Body mass index (BMI) was 34.3. The laboratory data obtained at admission showed leukocytosis (white blood cells, 18,650/mm³), C-reactive protein elevation (32.6 mg/dL), D-dimer elevation (7.7 μg/dL), and low serum albumin levels (1.8 g/dL). Computed tomography (CT) images obtained on admission showed inflammation spreading to the lower margin of the left kidney. We administered intensive care management including antibiotics and proteolytic enzyme inhibitors. On day 16, emergency CT and angiography were performed because he had melena and devel-

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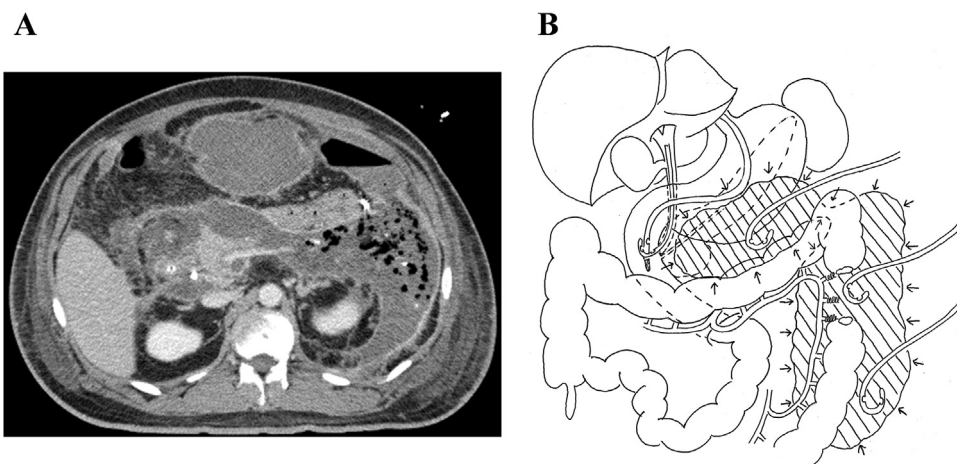


Fig. 1. Retroperitoneal abscess and drainage.

A: CT scans showed wide range of retroperitoneal abscess formation.

B: Ultrasound-guided percutaneous abdominal drainage was performed for 3 areas of retroperitoneal abscesses.

oped shock. Transcatheter arterial embolization (TAE) of the three straight arteries of the descending colon was performed. On day 30, CT scans showed wide range of retroperitoneal abscess formation (Fig. 1A). Ultrasound-guided percutaneous abdominal drainage using three pig tail catheters (6-Fr) was performed. The first catheter was inserted in the abscess on the front of the pancreas,

the second was inserted in the abscess around the splenic flexure of the left colon, and the third was inserted in the abscess around the descending colon (Fig. 1B). On day 36, ileostomy was performed because the appearance of drained pus from the abscesses became feces-like. Laparoscopic ileostomy was performed at the lower right abdomen. Laparoscopic intra-abdominal exploration was dif-

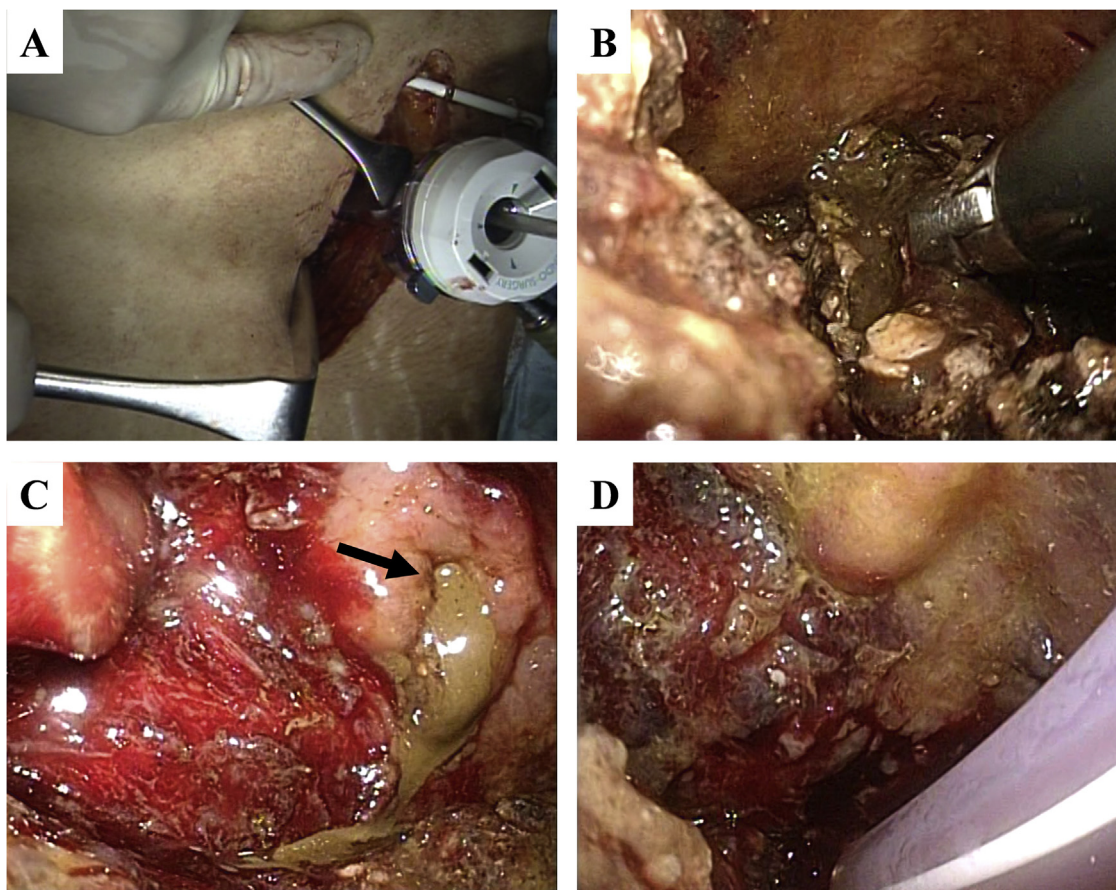


Fig. 2. Findings during surgery.

A: Retroperitoneal abscess was approached using percutaneous drainage catheter.

B: Infected necrotic tissues were removed under direct vision.

C: After the necrotic substances were removed, leakage of feces from the retroperitoneal perforated site of the colon was observed (arrow).

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