

Case report

- Haemosuccus pancreaticus: A RARE CASE OF UPPER GASTROINTESTINAL BLEED

- ABSTRACT

Haemosuccus pancreaticus is a life-threatening clinical entity. It is defined as bleeding from ampulla of Vater in which blood enters into duodenum from pancreatic duct. Haemosuccus pancreaticus may be due to the rupture of pancreatic pseudoaneurysm resulting in bleeding. Here is a rare case of active bleeding through main pancreatic duct into duodenum leading to GI bleeding. The incidence is 1:1500 case of GI bleeding. In this case report, we will discuss a case of 52-year male with complaints of pain in abdomen with recurrent episodes of melena since 2 months. Patient underwent CECT (Abdomen + pelvic) which suggestive of pseudoaneurysm of gastro duodenal artery followed by pseudoaneurysm embolization with coil microcatheter.

- Key Words: Haemosuccus pancreaticus, pseudoaneurysm

- INTRODUCTION

Haemosuccus pancreaticus is a life-threatening clinical entity. It is defined as bleeding from ampulla of Vater in which blood enters into duodenum from pancreatic duct. Haemosuccus pancreaticus may be due to the rupture of pancreatic pseudoaneurysm resulting in bleeding. Here is a rare case of active bleeding through main pancreatic duct into duodenum leading to GI bleeding. The incidence is 1:1500 case of GI bleeding. It was first reported in literature 1931 by Lower and Farrell^[1] as bleeding from an aneurysm of splenic artery coming via the pancreatic duct and ampulla of Vater to duodenum. The development of endoscopic as well as interventional radiology changed the diagnostic and therapeutic approach to various causes of GI bleeding. The newer diagnostic modalities like CECT, upper GI endoscopy reveal other rare causes of upper GI bleeding.

- CASE REPORT

A 52-year male came to opd with pain in abdomen, which was acute in onset, intermittent in nature. He also complaints of recurrent episodes of melena in the last 2 months. Patient was known case of alcoholic 6 years. On physical examination, patient was conscious, oriented, with following vitals; pulse was 86/min, bp; 130/80 mm of Hg; respiratory rate was 22/min. patient has sever pallor and jaundice. Laboratory investigations revealed a blood hemoglobin 3.4g/dl with total bilirubin 2.3mg/dl, for which patient underwent 3 times blood transfusion after admission. Computed tomography showed pancreatic parenchymal calcification noted in body and tail region, with evidence of few hypodense enhancing area noted involving head and body region of pancreas, largest measuring of 19*10mm in neck region suggestive of pancreatic pseudocyst. Evidence of focal outpouching of size 7*5mm noted in pancreatic head region is seen originating from gastro duodenal artery. Patient underwent gastroduodenal artery pseudoaneurysm embolization with coil microcatheter; visceral artery embolization for gastro intestinal bleeding with micro catheter.

- **DISCUSSION**

Haemosuccus pancreaticus is most commonly caused by a rupture of aneurysm associated with acute or chronic pancreatitis. Pseudoaneurysms of the hepatic, gastroduodenal and pancreaticoduodenal arteries have also been reported as sources of bleeding^[2,3]

Clinical symptoms and signs include upper GI bleeding as evidenced by hematemesis and Malena, of which Malena is more common, and epigastric pain resulting from the elevation of pressure in the pancreatic ducts caused by blood clots^[4,5].

There are two therapeutic options for this entity: surgery and angiographic embolization. Once the hemodynamic situation is under control, interventional radiographic methods are used for initial treatment coil embolization. Haemosuccus pancreaticus either because the pseudocyst is hemorrhagic or because it communicate with and erodes a peri cystic artery^[5]. HP may result from vascular ulceration caused by an intraductal stones. HP may result from vascular ulceration caused by a dilated and cystic main pancreatic duct, and arterial aneurysm and pseudoaneurysm, known to have a higher frequency in chronic pancreatitis.^[6,7]

Conclusions

HP may be the cause of upper GI bleeding in a patient with a history of chronic pancreatitis. Investigations should be carried out on all patients to get a diagnosis, ideally when there is active bleeding. These include CECT, selective arteriography of the celiac trunk and superior mesenteric artery, upper digestive endoscopy. In present case, contrast-enhanced computed tomography produced a high positive yield comparable to selective angiography.

References

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Fig. 1 Pre operative: Gastroduodenal artery aneurysm

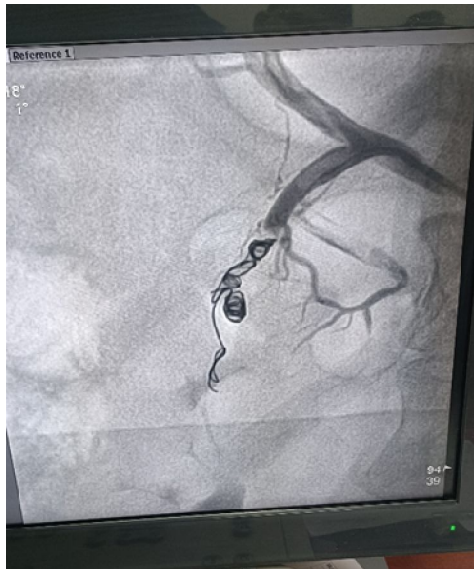


Fig. 2 Post operative: Gastroduodenal artery cannulation by using microcatheter