CASE SNIPPETS

Hydatid cyst in head of pancreas presenting with obstructive jaundice

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We report a patient with hydatid cyst in the head of the pancreas who presented with obstructive jaundice. At operation, the cyst was compressing the common bile duct and pancreatic duct. Excision of the cyst with choledochojejunostomy was performed. [Indian J Gastroenterol 1997; 16: 32]

Key words: Common bile duct, pancreatic duct.

Obstructive jaundice caused by extraluminal pressure on the terminal common bile duct (CBD) by a hydatid cyst in the pancreatic head is an uncommon condition. We report such an event.

A 22-year-old woman presented with progressive jaundice, itching and dull ache in the upper abdomen for the last two months, occasional fever, and recent vomiting. Investigations: serum bilirubin 8.4 mg/dL (direct 6.6), serum alkaline phosphatase 18 KA units. Ultrasonography showed a thick-walled cyst in the pancreas (4.3 cm x 4.6 cm) with internal echoes, compressing the terminal CBD. The diameter of the proximal CBD was 15 mm and of the pancreatic duct 8 mm. Repeat ultrasonography showed another small cyst in the posterior aspect of the right lobe of the liver. CT scan suggested choledocholithiasis with atrophic pancreatitis.

Endoscopic retrograde cholangiopancreatography showed dilated intrahepatic biliary radicals, dilated proximal CBD, compressed terminal CBD, and a cystic lesion in the head of the pancreas not communicating with the pancreatic duct (Fig).

On exploration, a cystic lesion about 5 cm in diameter was found at the head of the pancreas protruding from its posterior surface, with dilatation of the proximal CBD. It contained daughter cysts. Kocherization of duodenum, excision of endocyst, sterilization of the cyst cavity with 0.5% octrime and normal saline, and choledochojejunostomy were done. The patient recovered uneventfully. Histology confirmed hydatid cestode.

Hydatid disease of the pancreas is rare. Intraductal hydatid cyst of the pancreas was reported in one case earlier; the patient was treated with distal pancreaticoduodenectomy.1 The specimen revealed multiple cysts within the dilated pancreatic duct. In 1991, seven patients with hydatid cysts of pancreas were reported; four had cyst located in the head of the pancreas without obstructive jaundice and three had cyst in the body and tail.2 Two other cases were treated with resection of the protruding cyst and total cystectomy.3

Our case was unusual as the hydatid cyst was located in the head of the pancreas and was compressing the terminal parts of the CBD and pancreatic duct.

References

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Hepatic artery pseudoaneurysm and hemobilia following laparoscopic cholecystectomy

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Iatrogenic or accidental injury to the right hepatic artery or its branches can result in formation of pseudoaneurysm, which may rupture into the biliary system, leading to life-threatening hemobilia. We describe one such case following laparoscopic cholecystectomy and discuss its management. [Indian J Gastroenterol 1997; 16: 32-33]

Key words: Angiography, embolization

Laparoscopic cholecystectomy is now an established procedure for treatment of gallstones. Though vascular complications of this procedure are rare, these can result in severe morbidity or death. We present a rare case of
Fig: Celiac arteriogram showing aneurysm of right hepatic artery
right hepatic artery pseudoaneurysm with hemobilia following laparoscopic cholecystectomy.

A 44-year-old lady presented with right upper abdominal pain followed by hematemesis and melena. She had undergone laparoscopic cholecystectomy elsewhere one month ago. She was jaundiced. Endoscopy revealed blood issuing from the ampulla of Vater; celiac angiography revealed an aneurysm of the right hepatic artery (Fig). Attempts at embolization of the vessel failed. Surgical exploration revealed a 4-cm diameter pseudoaneurysm of the right hepatic artery, which necessitated ligation of the latter. A second laparotomy after a bout of massive hematemesis on the fourth postoperative day revealed the aneurysm to be pulsating; the aneurysm was opened, clots were evacuated and feeding vessels to the aneurysm were ligated. The communication of the aneurysm with the common bile duct was identified and repaired over a T-tube. The T-tube was removed 3 months later after angiographic confirmation of disappearance of pseudaneurysm.

Etiological pattern of hemobilia has changed with time; most cases reported now are related to blunt liver trauma, percutaneous drainage procedures, liver biopsy or open hepatobiliary surgery. Though vascular complications are known to follow laparoscopic cholecystectomy, hemobilia is very rare. Hemobilia due to pseudaneurysm of the hepatic artery is rare, but can occur following surgical damage during a difficult cholecystectomy or other biliary surgeries. Rupture of the pseudaneurysm into the extrabiliary bile ducts can result in hemobilia many weeks or months later.

Hemihapatectomy should be the last resort, and should be undertaken only for lesions close to the hilum that cannot be controlled by either angiographic embolization or operative ligation of the aneurysm.

Only eight cases of post-laparoscopic hemobilia have been reported in literature. Avoidance of excessive use of cautery which may result in thermal injury to surrounding vascular structures and conversion to open procedure in case of vascular injury may prevent this rare but life-threatening complication.

References

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Herpes simplex hepatitis
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We report a 76-year-old man who presented with hepatitis. IgM antibodies to herpes simplex virus were positive and scraping from skin lesions showed presence of herpetic inclusion bodies. The patient died 4 days after the onset of illness. [Indian J Gastroenterol 1997; 16: 33-34]
Key words: Inclusion bodies, systemic virusis

Herpes simplex virus infection is common in adults. In most instances it is merely an annoying condition but, occasionally, it can be life-threatening. We report an elderly man who presented with fulminating herpes simplex

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