Abstract

Hepatic artery pseudoaneurysms constitute a rare clinical entity. Management of pseudoaneurysm includes surgical ligation, stenting, transarterial embolization, and endoscopic ultrasound-guided coiling (EUS-GC). We planned to assess the collection with endoscopic ultrasound (EUS), and decided whether it was feasible for internal drainage or to perform a coiling procedure.

We present three sequential cases demonstrating different management approaches. Case 1 describes a patient with a hepatic pseudoaneurysm who underwent successful embolization through a EUS-guided HGS. In the first stage, a EUS-guided biliogastric anastomosis was performed through the left intrahepatic duct. The second stage involved the placement of coils to embolize the aneurysm. Three more coils of 8 mm size were placed and deployed. Postcoiling, EUS assessment still showed flow into a smaller cavity. During the second attempt, four coils of 10 mm size were collected into the most distal part of the aneurysm, but flow into a smaller cavity continued with high velocity.

Case 2 describes a patient with a pancreatic abscess from duodenum. A 74-year-old female presented with upper gastrointestinal bleeding with failed endoscopic hemostasis and a C loop of the duodenum with edematous duodenal mucosa. A EUS-guided choledochogastrostomy was then performed to dilate the cystoduodenostomy. We chose to dilate with a hurricane balloon up to 8 mm and then placed two 7 Fr double pigtail stents. We got an excellent drainage of frank pus and the pus was sent for culture and sensitivity. On follow-up, he was on intravenous antibiotics and discharged after 48 h. An ultrasound at 48 h revealed 3 ml collection. We plan to administer antibiotics for 10 days and review with magnetic resonance cholangiopancreatography at 3 weeks to see for leak and PD-stenting SOS.

Case 3 describes a patient with pyloric obstruction. A EUS-guided salvage of a misdeployed HGS stent was performed through a 19-gauge needle caused 80% obliteration of the sac. Packing with one coil of 10 mm and five coils of 6 mm size through a 19-gauge needle caused 80% obliteration of the sac. EUS-guided HGS was then performed to the misdeployed stent. Case 3 describes a patient with unresectable gastric cancer with pyloric obstruction. During deployment, a 19-gauge flex needle was used. He challenge was how much cavity with loss of guidewire. EUS-guided HGS was then performed. A 74-year-old female presented with upper gastrointestinal bleeding with failed endoscopic hemostasis and a C loop of the duodenum with edematous duodenal mucosa. A EUS-guided choledochogastrostomy was then performed to dilate the cystoduodenostomy. We chose to dilate with a hurricane balloon up to 8 mm and then placed two 7 Fr double pigtail stents. We got an excellent drainage of frank pus and the pus was sent for culture and sensitivity. On follow-up, he was on intravenous antibiotics and discharged after 48 h. An ultrasound at 48 h revealed 3 ml collection. We plan to administer antibiotics for 10 days and review with magnetic resonance cholangiopancreatography at 3 weeks to see for leak and PD-stenting SOS.

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**Endoscopic ultrasound-guided drainage of a pancreatic abscess from duodenum**

**Pankaj Desai**

Surat Institute of Digestive Sciences, Surat, Gujarat, India

A 56-year-old male patient presented with complaints of severe abdominal pain in the right paraumbilical region and epigastrium with fever and vomiting for 5 days. He had a history of acute pancreatitis related to alcohol before 6 weeks and had been admitted to the hospital elsewhere for 12 days. Investigations revealed a high total count of 18,700/cumm and clinically had tenderness and guarding in the right upper and paraumbilical region with fever. Computed tomography scan revealed a collection with some necrosis in the area of the C loop of the duodenum with edematous duodenal mucosa. Pancreatic duct (PD) was mildly dilated and common bile duct was prominent. Gallbladder was distended with sludge in it. We planned to assess the collection with endoscopic ultrasound and decide whether it is feasible for internal drainage or to call the surgeon. Highlights of this procedure – The puncture was possible only with a long loop position of the scope. A 19-gauge flex needle was used. He challenge was how much to dilate the cystoduodenostomy. We chose to dilate with a hurricane balloon up to 8 mm and then placed two 7 Fr double pigtail stents. We got an excellent drainage of frank pus and the pus was sent for culture and sensitivity. On follow-up, he was on intravenous antibiotics and discharged after 48 h. An ultrasound at 48 h revealed 3 ml collection. We plan to administer antibiotics for 10 days and review with magnetic resonance cholangiopancreatography at 3 weeks to see for leak and PD-stenting SOS.

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