CASE PRESENTATION

A 66-year-old white male with a recent admission for chronic pancreatitis secondary to alcohol abuse, with underlying hypertension and coronary artery disease, presented with abdominal pain and a painful lump in the right thigh for the past 24 hours.

He described a small tender bulge in the right inguinal area that became larger while sitting or standing and smaller when lying down.

Physical exam revealed epigastric tenderness and a small, reducible, fluctuant lump in the right inguinal area when patient was sitting or standing that disappeared when he was supine.

Routine clinical chemistry was normal but both amylase and lipase were elevated more than 3 × the upper limit of normal.

Questions

1. What is the most likely diagnosis of the tender and fluctuant right inguinal lump?
2. What is the next appropriate step for diagnosis?
3. What is the best therapeutic approach for this condition?

Figure 1. CT of abdomen and pelvis.

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Send in a brief case report. No more than one double-spaced page. One or two illustrations, up to four questions and answers and a three-quarter to one-page discussion of the case. Case to include no more than two authors. A $100.00 honorarium will be paid per publication.

Case should be e-mailed to: C. S. Pitchumoni, M.D. at pitchumoni@hotmail.com

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DISCUSSION

The CT abdomen/pelvis revealed a pseudocyst tracking along the right psoas muscle and continuing caudally via the iliopsoas complex to the right groin. A portion of the main pancreatic duct (PD) in the pancreatic body was dilated. Numerous small and large calcifications were seen in the pancreatic parenchyma.

Additional CT images revealed a large collection extending superiorly along the inferior aspect of the right hemidiaphragm and ending adjacent to the liver. There was a suggestion of a connection between the cyst and the pancreas on subsequent MRCP. An ERCP failed to pass a wire into the proximal PD due to stricture but demonstrated a connection between the PD and the pseudocyst.

CT guided aspiration of the iliopsoas fluid collection recovered 300 cc of yellow serous fluid with an amylase of 62,850 and a lipase of 167,220.

Psoas pseudocysts are uncommon and have even led to urgent surgical exploration of the inguinal area in search of an incarcerated inguinal hernia (1). This entity should be kept in mind in patients with a recent history of pancreatitis even without clinical or biochemical evidence of pancreatitis (2).

Repeated attempts at percutaneous drainage in our patient using in-dwelling pigtail catheters resulted in partial to complete resolution of the pseudocyst every time. This was followed however, by re-accumulation of fluid on removal of the catheter. An obstructed PD with upstream ductal disruption as seen in our patient would not be expected to respond to this approach (3).

Endoscopic drainage, either transpapillary or transmural, is often the approach of choice (3). In our patient the transpapillary approach could not be used because of the inability to pass a wire into the PD. Although the pseudocyst lay posterior to the transverse portion of the duodenum and anterior to the aorta, a transmural attempt to drain the pseudocyst was not attempted because the pseudocyst could not be accurately localized by endoscopic visualization.

The surgical approach is used when conditions for percutaneous or endoscopic approaches are not met or when they fail. This approach is also preferred if the pseudocyst contents are not sufficiently liquefied, if there is malignancy or complications such as hemorrhage, bowel or biliopancreatic obstruction (as in our case) and for complicated or multi-loculated pseudocysts (3).

Our patient is scheduled to have a Frey’s procedure that will core out the diseased pancreatic head and drain the pancreas into a jejunal Roux limb. The procedure would also eliminate the connection between the damaged pancreatic duct and the pseudocyst allowing it to resolve.

References