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Clinical Image

Pancreatic-Thoracic Fistula. An Unusual Complication of Pancreatitis☆

Fístula pancreato-torácica, una inusual complicación de la pancreatitis

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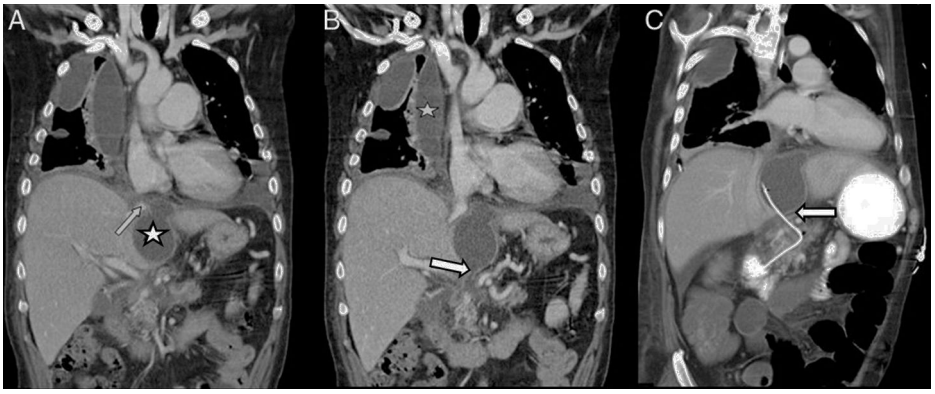

Fig. 1. (A and B) Coronal reconstructions of CT in a 47-year-old patient with a history of chronic pancreatitis complicated by a thoracopancreatic fistula. CT shows a loculated pleural effusion (star in B) connecting (arrow in A) with the pseudocyst (star in A), which in turn connects with the pancreatic duct (arrow in B). (C) Follow-up CT performed at 12 days, after ERCP and prosthesis placement (arrow in C), draining the pseudocyst and pleural collection via the pancreatic duct to the duodenum.

A 47-year-old man with a history of chronic pancreatitis and pancreatic pseudocyst was admitted for asthenia, anorexia, and weight loss, vomiting, fever, and pleuritic chest pain. Computed tomography (CT) revealed bilateral loculated pleural effusion, with a transdiaphragmatic fistula connection between the pseudocyst and the pancreatic duct, and right paramediastinal collection (Fig. 1).

The patient developed progressive respiratory failure and was transferred to the ICU.

Given the findings, bilateral pleural drainage tubes were placed, and fluid with acute inflammatory cytology and elevated amylase was obtained. A pancreatic prosthesis was placed using endoscopic retrograde cholangiopancreatography (ERCP) (Fig. 1).

The patient's clinical and radiological status improved after these procedures.

Thoracic complications of pancreatitis are infrequent (15%–50%). The most common is pneumonia with pleural effusion. Pseudocyst extending to the mediastinum, thoracopancreatic fistula and mediastinitis are rarer.

Pleuropancreatic fistula (0.4%) is an abnormal connection between the pancreatic duct and the pleura. It is most commonly seen as a result of chronic alcoholic pancreatitis, and should be suspected in the case of persistent abundant pleural effusion (particularly in the left side) with elevated amylase. The fistula can be detected by CT, MRI or endoscopy.[1,2]

Treatment includes control of the effusion, inhibition of pancreatic secretion, and isolation of the fistula by endoscopy or surgery.

References

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