Pancreatic Pseudocysts — Diagnosis and Treatment

Pancreatic pseudocysts are a complication of acute pancreatitis, and they are more common when the etiology is alcohol-related. These pseudocysts do not have an epithelial wall, and their fluid content is rich in amylase, lipase and trypsin. Abdominal CT scan is the diagnostic modality of choice to confirm the diagnosis of pancreatic pseudocysts and exclude complications. MRI or ERCP can be used to assess communication between the pseudocyst and the pancreatic duct, and if present, transpapillary drainage of the pseudocyst can be attempted.

Definition of Pancreatic Pseudocysts

Pancreatic pseudocysts are fluid collections that may occur few weeks after an episode of acute pancreatitis. These collections contain several pancreatic enzymes and do not have an epithelial wall.

Pancreatic pseudocysts are different from acute fluid collections that occur during the
episode of acute pancreatitis, where the latter is more of an inflammatory process.

Epidemiology and Etiology of Pancreatic Pseudocysts

Pancreatitis is more common in males, and so is the incidence of pancreatic pseudocysts.

Approximately 14.6% of the patients who experience acute pancreatitis are expected to develop a pancreatic pseudocyst as a complication. On the other hand, pancreatic pseudocysts are way more common in acute-on-chronic pancreatitis, especially of alcoholic etiology, and can be identified in up to 41% of the cases.

The most common etiologies for pancreatic pseudocysts are alcoholic pancreatitis and acute (on top of chronic) pancreatitis. Gallstone disease related pancreatitis can also cause pancreatic pseudocysts.

In children, blunt abdominal trauma is a common etiology for pancreatic pseudocysts.

Pathophysiology and Clinical Presentation of Pancreatic Pseudocysts

For pancreatic pseudocysts to form, disruption of the pancreatic ducts need to happen first. Pancreatitis, regardless of the etiology or trauma, can cause acute disruption of the pancreatic ductal system, which then allows for pancreatic enzymes to escape and to start an inflammatory process in nearby structures. This inflammatory process results in the formation of a fibrous wall around the pseudocyst where further fluid accumulates.

The size of these pseudocysts can range from 2 to 30 cm and they can be multiple, especially in alcoholic pancreatitis. 60% of the pseudocysts occur at the pancreatic tail, and their fluid has amylase, lipase and trypsin.

The most commonly presented symptom of pancreatic pseudocysts is abdominal pain. There is usually a recent history of acute pancreatitis, unless the etiology is abdominal trauma. Patients can also have anorexia or can complain of an abdominal mass, if the pseudocyst is large enough.

Pseudocysts can become infected, and in that case, patients would present with a fever. Pleural effusion, another acute pancreatitis complication, can co-occur with pancreatic pseudocysts.

Physical examination is usually unremarkable, unless the pseudocyst is large enough and can be palpated. Tenderness can be elicited in patients with pancreatic pseudocysts. If tenderness is severe or there is abdominal rigidity, pseudocyst rupture or infection has to be excluded.

Chest examination can reveal dullness to percussion and decreased breathing sounds in the lower lung fields due to pleural effusion. Fever can be present if the pseudocyst gets infected. Jaundice has been reported as a result of a sepsis caused by pancreatic pseudocyst infection.
Diagnostic Work-up for Pancreatic Pseudocysts

Patients who develop a pancreatic pseudocyst can have an elevated serum amylase and lipase levels, but this is not necessary for a diagnosis. Liver enzymes and bilirubin are usually elevated in gallstone pancreatitis and related pseudocysts.

Older patients who present with a pancreatic pseudocyst, without a clear history of recent pancreatitis, should have the cyst’s fluid aspirated and examined to exclude malignancy. Carcinoembryonic antigen is elevated in pancreatic malignant cysts.

The fluid content of the pseudocyst is usually of low viscosity, and pancreatic enzymes’ levels are elevated in the fluid aspirated from the pseudocyst.

Imaging is also crucial in the evaluation of a patient with a pancreatic pseudocyst. Ultrasonography can identify abdominal cysts but is not sensitive enough to be considered as the best choice to establish the diagnosis of a pancreatic pseudocyst.

Endoscopic ultrasonography is beneficial when the pseudocyst is symptomatic and transmural drainage through the stomach wall is planned.

The best imaging modality to diagnose pancreatic pseudocysts is a computerized tomography (CT) scan of the abdomen. A CT scan usually reveals a cyst-like structure in the pancreas that could be single or multiple as seen in the figure. Pancreatic calcifications, a marker of pancreatitis, can also be visualized on a CT scan. Pseudocysts can erode the splenic artery and cause intra-cyst hemorrhage, which can be excluded by a CT scan.

Endoscopic retrograde cholangio pancreatography (ERCP) is used for drainage of the pseudocysts but not as a diagnostic modality. Magnetic resonance imaging (MRI) is indicated in patients with fever or sepsis to exclude necrotizing pancreatitis.

Treatment of Pancreatic Pseudocysts

A wait-and-see approach is advisable in most cases of uncomplicated pancreatic pseudocysts as the majority of them resolve without any specific treatment. The decision to go for pseudocyst drainage should be based on the presence of symptoms and not the size of the pseudocyst.
The treatment of choice for symptomatic or infected pseudocysts, or when there is a concern about malignancy, is drainage. If drainage is planned, pancreatic pseudocyst anatomy has to be assessed, which can be achieved by either an ERCP or MRI study. If pancreatic duct strictures are identified, surgical drainage of the pseudocyst is recommended.

Larger symptomatic pseudocysts can cause abdominal pain that is related to eating fatty diets. In these patients, it is advisable to eat a low-fat diet and, if the pain is very severe, to switch to parenteral or enteral nutrition.

Patients with pancreatic duct stenosis might benefit from a stent placement, which facilitates the pseudocyst resolution. If a percutaneous drain is used, care should be taken to look for possible infection.

Percutaneous aspiration is used for diagnostic and not therapeutic intentions because the recurrence rate of the pseudocyst is high. Additionally, percutaneous aspiration can introduce pathogens to the pseudocyst and increases the risk of infection. Percutaneous catheter drainage is indicated in infected pancreatic pseudocysts.

When the pseudocyst’s wall thickness is < 1 cm, endoscopic drainage with ERCP or transmural through the stomach can be attempted.

ERCP drainage of the pseudocyst is achieved through a transpapillary approach. For this method to be possible, communication between the pseudocyst and the pancreatic duct needs to be confirmed. The communication between the pseudocyst and the pancreatic duct can be visualized either by MRI or with ERCP.

Transmural drainage is done when upper endoscopy reveals a stomach bulge due to the compression of the pseudocyst on the stomach wall. A small incision is made through the stomach wall and access to the pseudocyst is achieved. Placement of multiple pigtail stents is done, and a communication between the pseudocyst and the stomach cavity is secured, where the pseudocyst is allowed to drain.

Both ERCP and transmural drainage have similar efficacy and are safe procedures if performed by an experienced surgeon.

In 2013, AXIOS stents were FDA approved for the treatment of pancreatic pseudocysts.
These stents allow the drainage of the pancreatic pseudocyst into the gastrointestinal tract and are usually a temporary measure. Once the patient improves and the pseudocyst resolves, removal of the stent is indicated.

References


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