CASE REPORT

A 53-year-old man with a longstanding history of alcohol abuse presented to the Emergency Department with 3 days of worsening left upper quadrant abdominal pain, fever, and vomiting. He had noted increased left upper abdominal “swelling” over 1 month. The patient was febrile (38.7°C/101.7°F) and tachycardic (heart rate 112 beats/min), with otherwise normal vital signs. He had a large palpable mass in his left upper quadrant on physical examination. Laboratory assessments were significant for an elevated white blood cell count of 13,600/mm³. His liver enzymes and lipase were unremarkable.

A focused bedside ultrasound of the left upper quadrant was performed that identified a large heterogeneous cystic mass (Figure 1). A computed tomography (CT) scan of the abdomen with intravenous contrast revealed two large, walled-off fluid collections (Figures 2, 3).

DISCUSSION

An infected pancreatic pseudocyst is a serious complication of chronic pancreatitis. The incidence of pseudocyst formation in chronic pancreatitis ranges from 20% to 40% (1). Due to repeated episodes of pancreatitis or worsening pancreatic duct obstruction – pancreatic enzymes collect into a pseudocyst. Up to 40% resolve on their own (2). If they remain, the clinical presentation can vary based on the size and location(s). Severe complications include infection, local expansion, and pseudoaneurysm. Splenic involvement (as in this case) is exceedingly rare, with the most feared complication being massive hemorrhage (3). CT is the recommended imaging modality for diagnosis; however, bedside ultrasonography oftentimes can expedite the work-up if the pseudocyst is large and lies anterior (4). Evidence of infection warrants intervention. Percutaneous, endoscopic, and laparoscopic drainage modalities are available (5).

Figure 1. Bedside ultrasonography of the abdominal left upper quadrant showing a large, heterogeneous fluid collection.
REFERENCES


