

A Rare Case Report of Pseudocyst of Pancreas in Pregnancy

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Abstract: Pseudocyst in pregnancy is a rare condition whose management is not standardized. Hyperlipidemia is overrepresented as a cause of pancreatic pseudocysts in pregnancy, causing more cases than alcoholic and biliary pancreatitis combined. A 20 year old primi with 20weeks of gestation was referred from Obstetrics department in view of epigastric pain which is radiating to back since 15 days and early satiety. Initial size of the cyst was 7*5 cm. On conservative management, patient developed worsening of pain and increase in size of epigastric mass. On MRI abdomen a 20*15cm pseudocyst of pancreas is noted in the body of pancreas with wall thickness of 8mm which is abutting the posterior wall of stomach. We performed open cystogastrostomy at 24 weeks of gestation under general anesthesia with a 4cm epigastric incision. There is complete resolution of symptoms and cyst on followup. It should be differentiated from papillary cystic neoplasm. MRI abdomen is the IOC. The natural history is same as that of pseudocysts seen in non gravid patients. Asymptomatic pseudocysts should be managed conservatively. Symptomatic, enlarging, very large and complicated pseudocysts needs intervention. Open Cystogastrostomy can be safely done without any complications to mother and foetus in centres which do not have technical expertise to perform endoscopic cystogastrostomy. Preterm labour is the obstetric complication that may occur as a result of pseudocyst along with other complications that are associated with pseudocyst.

Keywords: pseudocyst, cystogastrostomy, hyperlipidemia, pregnancy

1. Introduction

Pseudocyst in pregnancy is a rare condition whose management is not standardized. Hyperlipidemia is overrepresented as a cause of pancreatic pseudocysts in pregnancy, causing more cases than alcoholic and biliary pancreatitis combined⁽¹⁾. The natural history of pancreatic pseudocysts in pregnancy appears similar to that in nongravid patients. Although pseudocysts may regress spontaneously, approximately 30%–40% are complicated by infection, rupture, hemorrhage, or obstruction of the stomach, small bowel, colon, or bile duct⁽²⁾.

2. Case Report

A 20 year old primi with 20weeks of gestation was referred from Obstetrics department in view of epigastric pain which is radiating to back since 15 days and early satiety. On USG a 7*5 cm pseudocyst was seen in body of pancreas. Her serum amylase and lipase levels were normal. She has no previous history of acute pancreatitis. There is no history of alcohol intake and no evidence of gallstones on USG. Her triglyceride levels were elevated. We kept her on Conservative Management. After 1 month patient presented with worsening of abdominal pain and epigastric mass. On clinical examination a 15*10cm epigastric mass is palpable which is cystic in consistency. On MRI abdomen a 20*15cm pseudocyst of pancreas is noted in the body of pancreas with wall thickness of 8mm which is abutting the posterior wall of stomach. On upper GI endoscopy bulge is seen in body of the stomach. Ideally endoscopic Cystogastrostomy is the procedure of choice in this patient, but due to lack of technical expertise in our hospital we performed laporotomy. At 24 weeks of gestation Open cystogastrostomy was done under GA with a 4cm epigastric incision. Patient was discharged after 5 days without any postoperative complications. On follow up at 32 Weeks of gestation there is complete resolution of cyst on USG and without any recurrence of symptoms. At 37 weeks of gestation she delivered a healthy female child of weight 3.5kg through Normal vaginal delivery without any complications.

3. Discussion

Pseudocyst in pregnancy is a very rare condition, only 12 case reports had been published till now since 1980. Seventy-five percent of published cases of known parity was primiparous. Pancreatitis is a rare but serious condition in pregnancy, occurring in less than 1 in 3000 deliveries. Pancreatic pseudocysts complicate 5% of cases of pancreatitis, or fewer than 1 in 60,000 deliveries.

Although gallstones are the most common cause of pancreatitis in pregnancy, hyperlipidemia is by far most common cause in pseudocyst complicating pregnancy. USG is the initial investigation of choice. MRI abdomen is the IOC for pseudocyst of pancreas in pregnancy. The natural history of pancreatic pseudocysts appears similar to that in nongravid patients because pseudocysts less than 5 cm shrank or resolved while those greater than 5 cm remained the same size or enlarged¹.

Asymptomatic pseudocysts should be managed conservatively till delivery but an assisted vaginal delivery or cesarian section is preferred as due to vasalva in normal vaginal delivery there might be rupture of pseudocyst at the time of delivery. Symptomatic, enlarging, very large, or complicated pseudocysts require drainage. Although the management of pancreatic pseudocysts is not standardized in pregnant patients, the second trimester is generally considered the safest time to intervene⁽³⁾.

It should be differentiated from papillary cystic neoplasm of pancreas, which occurs predominantly in young women and whose growth may be enhanced by progesterone. Factors to help differentiate inflammatory from neoplastic fluid collections include: serum amylase level, which is elevated in 50% to 75% of pseudocysts and 5% of pancreatic neoplasms; cyst amylase level, which is normal in neoplasm and elevated in inflammatory fluid collections; ultrasonography demonstrating multiple cysts or internal septa that suggest neoplasm⁽¹⁾.

4. Conclusion

Pseudocyst of pancreas is a rare condition whose management is not yet standardized; Hyperlipidemia is by far the most common cause. MRI abdomen is the IOC. The natural history is same as that of pseudocysts seen in non gravid patients. Asymptomatic pseudocysts should be managed conservatively. Symptomatic, enlarging, very large and complicated pseudocysts needs intervention. If the pseudocyst is located posterior to stomach within < 1cm from stomach wall cystogastrostomy through either endoscopic or open cystogastrostomy is preferred. Open Cystogastrostomy can be safely done without any complications to mother and foetus in centres which do not have technical expertise to perform endoscopic cystogastrostomy. Preterm labour is the obstetric complication that may occur as a result of pseudocyst along with other complications that are associated with pseudocyst.

References

- [1] Eddy JJ, Lynch GE, Treacy DE. Pancreatic pseudocysts in pregnancy: a case report and review of the literature. *J Perinatol* 2003;23:69–72
- [2] A Large Pancreatic Pseudocyst Complicating Pregnancy
Jessica Bernica* and Robert Jay Sealock
- [3] Habashi S, Draganov PV. Pancreatic pseudocyst. *World J Gastroenterol* 2009;15:3