SEVERE POSTPANCREATECTOMY HEMORRHAGE (PPH) OVER ONE YEAR FOLLOWING WHIPPLE PROCEDURE: A CASE REPORT

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Background

Postoperative hemorrhage is one of the most severe complications following pancreaticoduodenectomy. PPH occurs in less than 10% of patients undergoing a Whipple procedure but accounts for 10-38% of perioperative mortality.[1] Median onset of delayed PPH has been recorded between 10-27 days, but rare case reports have documented PPH up to 240 days following the index procedure.[2,3]

Aim

To describe a rare case of PPH presenting as an upper gastrointestinal bleed (UGIB) over one year following pancreaticoduodenectomy.

Description

A 52-year-old man presented with hematemesis, hematochezia and hemodynamic instability 15 months following an uncomplicated pancreaticoduodenectomy for a mucinous cystic neoplasm causing biliary pancreatic obstruction. On initial work-up, his hemoglobin level was 129 g/L, down from 159 g/L four months prior. Gastroscopy revealed a large amount of clotted blood in the stomach. Inspection of the afferent and efferent limbs of gastrojejunostomy revealed no active bleeding. A Dieulofoy's lesion was suspected on the lesser curvature of the stomach which was treated with endoscopic clips and the patient stabilized with resuscitation.

Forty-eight hours following admission, the patient developed hematemesis and became hemodynamically unstable. Gastroscopy and CT angiography (CTA) were repeated, but no bleeding was localized. After a third episode of hemodynamic instability, the patient was taken to the operating room for laparotomy and anterior gastrotomy which revealed clotted blood in the stomach, but the source remained unknown. The bleeding persisted and a repeat CTA revealed hemorrhage from the gastroduodenal artery (GDA) stump into the pancreaticobiliary limb. Coil embolization was performed and the bleeding was controlled (Figure 1). The patient fully recovered and was discharged several days later.

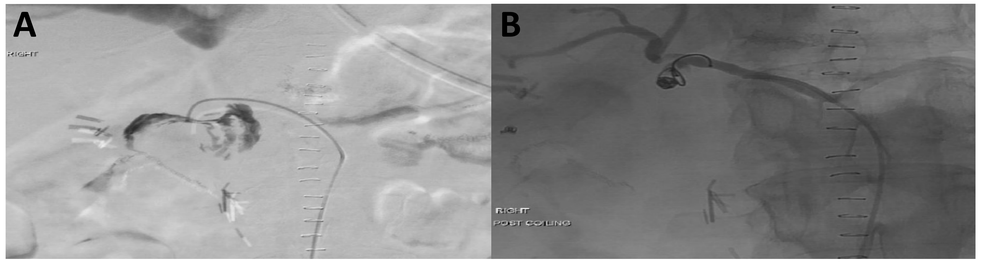


Figure 1. Coil embolization of GDA stump to control bleeding (A. Active extravasation of contrast at GDA stump into pancreaticobiliary limb B. Post embolization angiography)

Discussion

We have described a case of severe PPH, 15 months following pancreaticoduodenectomy, presenting as UGIB. Etiology of this bleed is uncertain but may be secondary to prior pancreatic leak, weakening the GDA stump, combined with ulceration or infection near the staple line. Physicians should consider early angiography in patients with UGIB following pancreatic surgery.