

## MINI REVIEW

# Inpatient Management and Treatment of Pancreatic Pseudocyst Drainage and Giant Pancreatic Pseudocyst in Children

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## INTRODUCTION

The production of pancreatic pseudocysts is a common complication of pancreatitis caused by alcohol or gallstones. The formation of a giant pancreatic pseudocyst is a rare but deadly consequence of pancreatitis. Giant pancreatic pseudocysts may necessitate surgery due to the huge volume of pancreatic fluid containing active enzymes [1].

Shortness of breath, general malaise, and dyspnea on exercise were all symptoms of a large pancreatic pseudocyst in a 56-year-old woman with a history of severe alcohol consumption. A huge pancreatic pseudocyst measuring up to 22 cm in diameter was discovered on the initial computed tomography (CT) scan. The patient was admitted to the hospital and had an endoscopic cystogastrostomy. The cystogastrostomy stent was removed and replaced with a pigtail catheter once the patient was stabilised. Three-month follow-up CT scan.

Drainage of the pseudocyst is the most appropriate treatment for gigantic pancreatic pseudocysts due to their huge size. The goal of draining pseudocysts can be accomplished through a variety of therapy techniques. An endoscopic ultrasound-guided cystogastrostomy is one of the most regularly used procedures, and this case demonstrates it as a viable therapeutic choice for big pancreatic pseudocyst [1].

Pancreatic pseudocysts are a fairly common consequence of persistent alcoholism and pancreatitis. However, only a few examples of gigantic pancreatic pseudocysts, those with a main diameter of 10 cm or more, have been documented in the literature. Reduced occurrence due to more improved diagnostic and therapeutic technologies and/or variations in sizing

classification could be contributing factors to the paucity of data about gigantic pancreatic pseudocysts. When 10 cm or larger in main diameter, adjectives were referred to as 'large' or 'huge' rather than 'giant' in some texts. This case shows how a cystogastrostomy was used to surgically drain a large pancreatic pseudocyst [2].

This is the first account in the literature of an idiopathic large pancreatic pseudocyst (IGPP) producing intestinal blockage, intra-abdominal hypertension (IAH), and abdominal compartment syndrome (ACS). Because to its rarity, lack of a history of pancreatitis or pancreatic damage, and distinctive clinical presentation, diagnosing IGPP in an emergency is difficult. The gold standard in identifying pancreatic cysts is abdominal contrast-enhanced computed tomography (CECT) (PP). PP has been treated in a variety of ways, according to the literature [3].

A subcapsular splenic hematoma is an uncommon pancreatitis complication. The treatment of subcapsular splenic hematoma is still debatable. For the first time, we provide a case of a massive subcapsular splenic hematoma with a big pancreatic pseudocyst that was effectively treated with splenic artery embolization and US-guided pancreatic pseudocyst percutaneous drainage. After 2 weeks, a repeat CT-Abdomen revealed the removal of the pancreatic pseudocyst and many regions of infarction on the spleen, as well as a considerable reduction in the splenic subcapsular hematoma. After nearly a month in the hospital, the patient was discharged with the drainage tube in place, and about two weeks later, the drainage tube was withdrawn after a CT scan confirmed a decrease in the volume of the subcapsular hematoma [4].

Endoscopic drainage for pancreatic and peripancreatic fluid collections (PFCs) is becoming more popular as a less intrusive option to surgical or percutaneous drainage. Endoscopic ultrasound-guided transluminal drainage (EUS-TD) has recently established the gold standard for nonsurgical PFC therapy and is a safe operation. EUS-TD ensures a safe puncture by avoiding blood vessels in the way. PFCs were treated with one or multiple plastic stents (associated with a nasocystic catheter) for EUS-TD. Covered self-expandable metallic stents (CSEMSs) have lately been used to provide a safer and more efficient access method

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for internal drainage. The optimum technique and stent to employ in endoscopic drainage for PFCs was the subject of our review [5].

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