Reversible bilateral ureteric obstruction due to a pancreatic pseudocyst

G E Gibson, E Tiernan, C C Cronin, J B Ferriss

Abstract
An unusual case of bilateral ureteric obstruction and hydronephrosis due to pancreatic pseudocyst formation, after an episode of acute pancreatitis is reported. All abnormalities resolved with conservative management. Possible reasons for such ureteric obstruction include periureteric fat necrosis by pancreatic enzymes and compression by the inflammatory mass.

Pancreatic pseudocysts are localised collections of pancreatic secretions occurring as a result of pancreatic inflammation and ductal disruption. They develop in about 10% of patients with acute alcoholic pancreatitis. Pseudocysts may be complicated by infection, haemorrhage, rupture, and by compression of adjacent organs. Bilateral ureteric obstruction due to pancreatitis has been reported once before and in that case enzymatic digestion of the ureters was the likely cause of obstruction. We present a case of bilateral hydroureter and hydrenephrosis in which compression from a large pseudocyst seems to have been the cause. Complete resolution occurred with conservative management.

Case report
A 36 year old man with a background of heavy alcohol intake presented to another hospital with a four day history of abdominal pain, vomiting and jaundice. Plasma hepatic transaminase enzyme activities were raised and a diagnosis of alcoholic hepatitis was made. The acute symptoms resolved. Persistent pyrexia and bilateral pleuritic chest pain and effusions, however, prompted transfer to this hospital.

On admission here, he had a low grade pyrexia, bilateral pleural effusions, and moderate smooth hepatomegaly. Results of investigations included: haemoglobin 10 g/dl (normal range (NR), 14–18 g/dl), white cell count 12.9×10⁹/l (NR, 4–8–10–8×10⁹/l), platelets 673×10⁹/l (NR, 150–400×10⁹/l), and an erythrocyte sedimentation rate 132 mm/hr. Mean corpuscular volume was 99 fl (NR, 80–92 fl) and plasma gamma glutamyl transferase was 2.9 ukat/l (NR, 0.1–0.8 ukat/l). Serum creatinine, amylase, serum aspartate transaminase, and serum alanine transaminase were within the normal range. Plasma albumin was 28 g/l (NR, 36–44 g/l). Chest radiography confirmed bilateral pleural effusions, more considerable on the left, and linear atelectasis at the lung bases. Lung perfusion scan was normal. Pleural aspirate was an exudate.

Ultrasonography showed hydrenephrosis of the left kidney, which was confirmed by intravenous urography. Computed tomography (CT) of the abdomen and pelvis showed appreciable pancreatic enlargement and widespread increase in the amount of soft tissue in the retroperitoneum extending into the pelvis, with additional soft tissue masses in the presacral region and the left side of the pelvis. The findings were highly suggestive of recent pancreatitis with pseudocyst formation.

The patient was managed conservatively with regular monitoring of renal function and of pseudocyst size. Six weeks later, CT scanning showed a bulky pancreas and a large pseudocyst of the lesser sac, with fluid tracked down on the left side of the retroperitoneum in the anterior compartment, anterior to Gerota’s fascia as far as the left iliac fossa. There was now bilateral hydrenephrosis with obstruction at the pelvic inlet (Figs 1 and 2). No surgical intervention was undertaken. The patient was regularly reviewed. Ultrasonography four months later showed improvement, with resolution of hydrenephrosis on the left and minimal hydrenephrosis on the right. CT scan, ten months after his initial presentation, showed persistent irregular enlargement of the body and the tail of pancreas with multiple small pseudocysts. Hydrenephro-
Figure 2: Computed tomography scan at the fifth lumbar vertebra showing left sided retroperitoneal mass (right arrow) abutting on ureter (left arrow).

Figure 3: Computed tomography scan showing resolution of hydronephrosis. Pancreas (arrowed) remaining enlarged.

Discussion
Pancreatic pseudocyst formation is a complication of severe pancreatitis and most commonly follows alcoholic pancreatitis. Pancreatic pseudocysts extend along the fascial planes, following the line of least resistance and may extend from the mediastinum to the groin. Adjacent structures may be eroded or compressed. It is rare, however, for the urinary tract to be affected. A fistula between a pancreatic pseudocyst and the left renal pelvis has been reported, as has a left pancreatic perirenal fistula. Ransohoff described a patient with a pseudocyst that eroded directly into the kidney causing gross haematuria. Pseudocysts may compress or indent the kidney or may displace the ureter. Isolated ureteric obstruction is a rare complication of pancreatitis.

One previous case of bilateral ureteric obstruction after pancreatitis has been reported and it was also in an alcoholic patient with a large pseudocyst. In contrast with our patient, ureteric obstruction was complete. At surgery, both ureters contained isolated necrotic segments and histological examination showed obstructed ureters with acute and chronic inflammation surrounded by fat necrosis and calcification. Direct compression of the ureters was not the cause of the obstruction, which was thought to be because of enzymatic degradation of the ureters. In contrast with our patient, although no material was available either before or after death for histological study, the absence of complete obstruction and the spontaneous resolution suggests that the ureteric obstruction was a result of compression from the pseudocyst.

There is controversy about the management of pancreatic pseudocysts. Operative intervention is recommended for pseudocysts greater than 6 cm that persist more than six weeks or that are of an indeterminate age, the rationale being the presumed high rate (30–50%) of life threatening complications. Operative management is not without risk, however, as it has a reported 5–12% death rate. Our experience with this patient agrees with the view that many such patients can be managed conservatively with careful clinical and radiological follow up.

In summary, we report a case of a retroperitoneal pancreatic pseudocyst causing distal bilateral ureteric obstruction and bilateral hydronephrosis. Complete resolution occurred with conservative management.

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Gut 1993 34: 1267-1268
doi: 10.1136/gut.34.9.1267

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