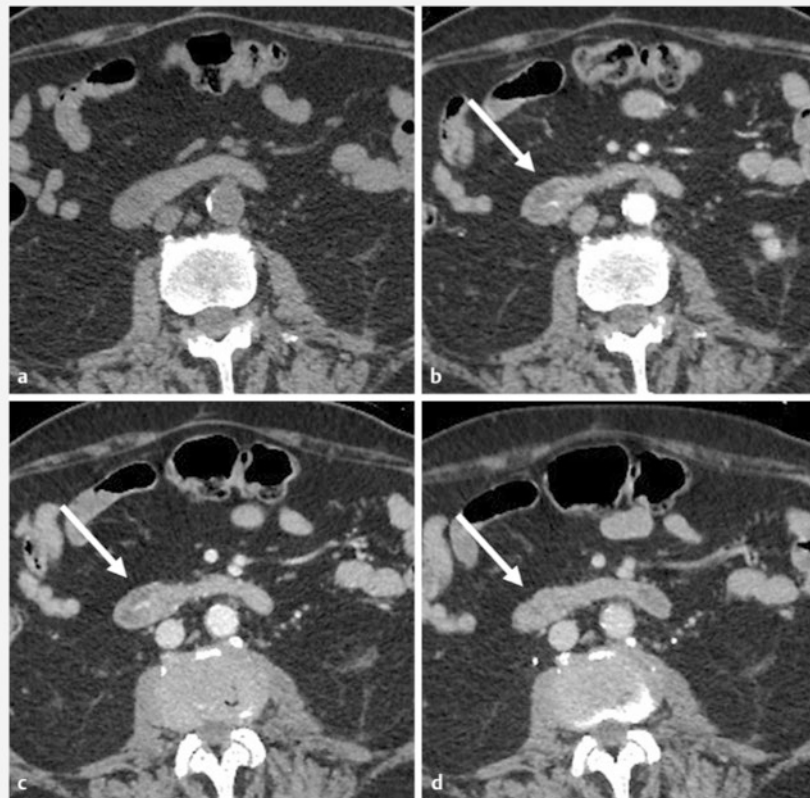




## Acute pancreatitis following endoscopic hemostasis of a periampullary Dieulafoy lesion: successful rescue by endoscopic retrograde cholangiopancreatography



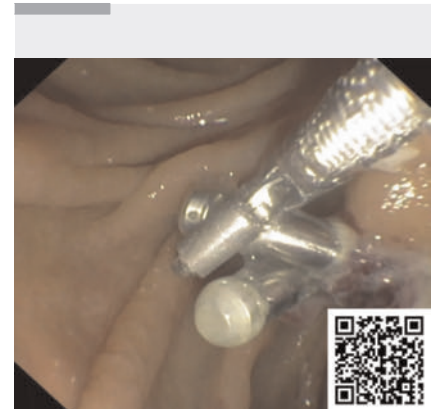
**► Fig. 1** Unenhanced (a) and contrast-enhanced multidetector-CT (b, d), showing in the descending duodenum progressive contrast medium extravasation on vascular lesion during dynamic arterial (b), portal venous (c) and equilibrium (d) phases.

Periampullary Dieulafoy lesions are a rare source of upper gastrointestinal bleeding. Endoscopic treatment in this region carries a risk of post-procedural pancreatitis due to inadvertent papillary obstruction [1,2].

We present the case of an 87-year-old man with a history of recurrent gastrointestinal bleeding due to angiodysplasia and Dieulafoy lesions, who was admitted with melena and dyspnea. On presentation, he was hemodynamically stable but severely anemic (Hb 5.2 g/dL). Laboratory tests showed normal liver function and pancreatic enzyme levels. Following transfusion of three units of

red blood cells, CT imaging identified a hypervascular lesion in the second portion of the duodenum (► Fig. 1). Urgent esophagogastroduodenoscopy revealed active bleeding from a periampullary Dieulafoy lesion, treated with epinephrine injection and placement of two endoscopic clips.

Fourteen hours later, the patient developed mesogastric pain. Laboratory findings showed a marked elevation in amylase (1236 U/L) and a mild increase in bilirubin (1.3 mg/dL). CT scan reported duodenal wall hematoma and edematous acute pancreatitis. ERCP confirmed that the two endoclips were in place,



**► Video 1** Endoscopic removal of an endoclip obstructing the papilla, originally placed for hemostasis of a bleeding Dieulafoy. ERCP allowed cannulation of both biliary and main pancreatic ducts, followed by successful stenting and decompression.

but one directly over the papillary orifice (► Video 1). The obstructing clip was carefully removed using a foreign body retrieval forceps, resulting in immediate drainage of dense black bile. Both pancreatic and biliary ducts were successfully cannulated. A 7Fr×5 cm pancreatic stent was placed for ductal protection, followed by 6 mm hydrostatic dilation and deployment of a 10Fr×9 cm biliary stent for decompression.

Follow-up imaging 5 days later showed a reduction in pancreatic edema. Hemoglobin increased to 9.2 g/dL, and amylase levels decreased to 297 U/L.

This case illustrates a rare complication of clip-induced papillary obstruction and highlights the importance of early recognition and minimally traumatic clip removal using foreign body retrieval forceps followed by biliopancreatic stenting as an effective endoscopic strategy.

Endoscopy\_UCTN\_Code\_TTT\_1AR\_2AK

## Conflict of Interest

Boškosi I. is a consultant for Apollo Endosurgery, Boston Scientific, Nitinotes, Olympus, Pentax, Cook Medical, Microtech, ERBE, Siemens, Myka labs, and Endo Tools Therapeutics S.A., gives sponsored lectures for Apollo Endosurgery, Boston Scientific, Cook Medical, and Microtech, is the recipient of research grants from Apollo Endosurgery, Endo Tool Therapeutics, and ERBE, and is on the scientific advisory boards of Nitinotes and Myka labs. Spada C. has received speaker's fees and travel support from AnX Robotics and Medtronic; speaker's fees from Olympus, Boston Scientific, Pentax, and Norgine. All other authors have no conflict of interest.

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