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Abstract Discussion Forum **(0)**

Number: Su1424

SINGLE PORT VARD WITH CONTINUOUS IRRIGATION AND DRAINAGE: A MODIFICATION OF VARD

Society: SSAT

Track: Esophageal Diseases

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Introduction:

Necrotizing Pancreatitis is known to occur in approximately 20% patients with Acute Pancreatitis. It is associated with increased morbidity which requires interventional, endoscopic or surgical procedures with prolonged hospital stay. Management has shifted from highly morbid open necrosectomy to more minimally invasive techniques. We illustrate a case of Infected Necrotising Pancreatitis of biliary etiology which was managed with step up approach but eventually required minimally invasive surgical debridement.

Case details:

A 43 year male presented with complaints of abdominal pain and fever. Abdominal examination revealed a vague and tender upper abdominal mass. Labs revealed Leukocytosis(22,100/cu.mm). Ultrasonography revealed 10x6 cm peripancreatic collection with cholelithiasis. He was given a trial of conservative management with antibiotic therapy but had persistant fever and leukocytosis with repeat blood culture showing Klebsiella pneumonia. Contrast CT of the Abdomen on day 17 of pancreatitis showed 12 x 6 cm collection with a thin wall suggestive of Walled Off Necrosis with evidence of a distal CBD stone. He underwent EUS Guided Cystogastrostomy and Nasojejunal Tube insertion. He showed clinical improvement but had persistent leukocytosis and failure to thrive. Further investigations on day 31 of pancreatitis revealed inadequately drained collection with solid debris within it. He then underwent Ultrasound guided percutaneous drain insertion with serial upgradation from 14Fr catheter upto 24Fr catheter. He continued to have persistent fever spikes and Leukocytosis. Repeat CT on day 41 of pancreatitis showed residual peripancreatic collection with pancreatic necrosum. He then underwent surgical debridement by Video Assited Retroperitoneal Debridement (VARD). During the procedure we used a single 10 mm trocar after minimal dilation of the drain tract and utilising a sponge holder parallel to the trocar the necrosum was removed under vision. 32 Fr drain along with 10 Fr infant feeding tube were inserted through the same tract. We utilised IFT for ingress and drain as egress for the irrigation fluid. Postoperatively cavity irrigation was continued. He showed rapid improvement following surgical debridement with follow up CT Abdomen on day 52 of pancreatitis showing near complete resolution of the peripancreatic necrosum. He was followed up at 2 months and was doing well.

Conclusion:

This case highlights the turbulent course of necrotising pancreatitis which requires constant reassessment and invasive procedures requiring surgical debridement. Minimally invasive procedures with single trocar VARD might reduce risk of surgical complications like bleeding and colonic fistula formation.

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