Delayed Pancreatic Fistula after Left Nephrectomy: A Rare Complication

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ABSTRACT

Pancreatic cutaneous fistulas are rare but a possible complication of a kidney surgery. The anatomical proximity of the tail of the pancreas to the left kidney plays a key role in this matter. The relevant factors are also the size of the kidney tumor and the coexisting inflammatory infiltration as well. The reason of fistula formation is the imperceptible intraoperative damage to the pancreatic tissue and opening of pancreatic ducts. We are reporting a case of a 40-year-old patient who developed pancreatic cutaneous fistula after 10 years of left nephrectomy leading to skin excoriation. He was treated conservatively with octreotide and the fistula healed spontaneously. In conclusion, the pancreatic fistula is a rare complication of left nephrectomy.

Keywords: Delayed pancreatic fistula, Left nephrectomy, Octreotide.

AMEI's Current Trends in Diagnosis & Treatment (2019): 10.5005/jp-journals-10055-0067

INTRODUCTION

A pancreatic fistula is an important complication that may develop due to intimate relationship of the tail of the pancreas to the left kidney and can be a possible complication of left nephrectomy performed for inflammatory or tumor disease of the kidney.¹ We present a case in which a 40-year-old patient developed a pancreatic cutaneous fistula after 10 years of left nephrectomy leading to skin excoriation. The patient responded to subcutaneous injections of octreotide, which led to fistula closure and healing of excoriation.

CASE DESCRIPTION

A 40-year-old patient presented with a discharging fistula in the left lumbar region with skin excoriation (Fig. 1). He underwent left-sided nephrectomy for the nonfunctioning left kidney more than 10 years ago. He was treated conservatively for the same as an OPD case; he received an injectable somatostatin analog, i.e., octreotide along with antibiotics and wound care, and the fistula healed spontaneously with medical treatment (Fig. 2).

DISCUSSION

Pancreatic cutaneous fistulas are rare but a possible complication of a kidney surgery.¹ The anatomical proximity of the tail of the pancreas

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How to cite this article: Singh B, Gill S, Sandhu M, *et al.* Delayed Pancreatic Fistula after Left Nephrectomy: A Rare Complication. AMEI's Curr Trends Diagn Treat 2019;3(2):77–78.

Source of support: Nil

Conflict of interest: None

to the left kidney plays a key role in this matter. The relevant factors are also the size of the kidney tumor and the coexisting inflammatory infiltration as well. The reason of fistula formation is the imperceptible intraoperative damage to the pancreatic tissue and opening of pancreatic ducts.² The most important factor in diagnostics is the increase (at least threefold) of the amylase level (usually over 2,000) in the liquid collected from the fistula. In 30–50% of cases conservative treatment is successful, which includes discontinuing oral nutrition, antibiotic therapy based on microorganisms' species diagnosed, and administering somatostatin analogs, which decrease

Fig. 1: Skin excoriation due to pancreatic secretions

Fig. 2: After treatment with octreotide

exoteric secretion of the pancreas³ (our patient also responded to conservative treatment with somatostatin analogs). Total parenteral nutrition (TPN) usually turns out to be effective in a conservative therapy of pancreatic fistulas, though the same was not needed in our patient as well. More invasive methods of treatment are endoscopic ones—sphincterectomy, prosthetic restoration of the Wirsung's duct, or open surgery in the form of a fistulojejunostomy/pancreatic resection if a patient does not respond to conservative treatment and is only needed rarely.⁴

CONCLUSION

A pancreatic fistula is rare complication of left nephrectomy. Majority of cases can be managed with conservative treatment.

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