











**Table 2.** Summary of management.

Case. No	Intercostal chest tube drainage	Octreotide and other conservative measures	X-ray for pseudocysts	ERCP & stenting	Surgery	Hospital stay (No. of days)
1	ICD for right pleural effusion	Successful	-	Not attempted	-	10
2	ICD for right pleural effusion	Successful	Radiological percutaneous pigtail drainage for infected abdomino-thoracic pseudocyst	Unsuccessful	-	36
3	ICD for left pleural effusion	Not successful	-	Sphincterotomy, bridging stent across ductal disruption	-	15
4	Aspiration of left pleural fluid	Not successful	-	Sphincterotomy, decompressive ductal stenting	-	10
5	ICD for right pleural effusion	Not successful	Endosonoguided aspiration and transmural gastric drainage of pseudocyst	Not attempted	Distal pancreatectomy and proximal pancreatico jejunostomy	26

drainage of mediastinal pseudocysts is also possible and various approaches including indirect drainage by draining the abdominal component of pseudocyst as in second case above, paraspinal extrapleural CT guided approach or transhepatic subxiphoid approach has been described [11]. A successful percutaneous radiological treatment of the associated collection along with conservative and supportive measures may be all that is required in some cases and may result in clinical improvement with no further therapy needed for pancreaticopleural fistula or ductal disruption as noted in second case. Endoscopic transmural pseudocyst drainage has a low complication rate [10]. A common endoscopic approach is transmural drainage – placing stents through the gastric or duodenal wall and is done through a EUS scope. The prerequisites are no vascular structures are present between the gastric wall and pseudocyst, and the distance between the gastric or duodenal wall and the pseudocyst should be less than 1 cm [12]. Initial technical success was noted in the fifth case above, this was however followed by stent dislodgement. The possible reasons for this could have been the immature cyst walls, lack of firm abutment of the cyst with the gastric wall and a relatively small size of the cyst. Persistence of symptoms in this patient and lack of adequate response to conservative management lead to surgical intervention.

Surgery is needed in patients not responding to conservative and medical management or endoscopic stenting and also in patients with recurrence of symptoms. Surgery involves removal of the diseased portion of the pancreas by partial pancreatectomy and pancreatico jejunostomy. Surgery is a major endeavor in these patients and is not without risks with somewhat stormy but manageable post-operative course. Simpler forms of surgery, from the thoracic approach with use of pedicled intercostal muscle flap tagged around the fistula into diaphragm to close the pancreatico-pleural fistulous tract have also been described [13]. Some studies have also demonstrated shorter hospital stay in patients who were operated early in the course of disease [14] (Table 2).

The management strategy needs to be individualized for each patient depending on the clinical situation. Follow up is essential for signs of recurrence. Chest X-ray and ultrasound are the most basic investigations which can be offered during periodic OPD visits. It should be remembered that these patients have established chronic pancreatitis, new complications developing due to their underlying condition including recurrent acute exacerbations is to be expected.

**Conflict of Interest**

Authors declare that they have no conflict of interest to disclose.

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