



2020 Annual Meeting

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SP 4. FULMINANT GASTROINTESTINAL BLEEDING AS A LATE COMPLICATION AFTER ISOLATED PANCREAS TRANSPLANT

Presenter: Tara Barry MD | University of South Florida
TM Barry, CQ Wang, PC Kuo, VD Bowers

Background: Late vascular complications of pancreas transplant.

Methods: A 42 year-old female with type 1 diabetes underwent isolated pancreas transplant to R common iliac artery (CIA) and IVC with duodenojejunal anastomosis in 2009 with subsequent rejection in 2018. She presented in 2019 with one month of melena progressing to hematochezia, nausea and dizziness. Hemoglobin was 6.7g/dL. Esophagogastroduodenoscopy (EGD) with no bleeding, colonoscopy had red blood, scattered ring like lesions and dusky mucosa in the descending colon. Repeat EGD/push enteroscopy with clot extending 100cm from mid jejunum to proximal ileum, no source identified. Interventional Radiology (IR) performed multiple mesenteric angiograms that did not demonstrate active bleeding. Computed Tomography (CT) scan showed atrophic native and transplanted pancreas replaced by calcification. She had recurrent hematochezia and hematemesis, went into cardiopulmonary arrest, required massive transfusion and vasopressor support with eventual return of circulation.

Results: CT scan reviewed by IR with R CIA pseudoaneurysm. R femoral arteriogram revealed massive extravasation from ruptured pseudoaneurysm at the mid R CIA, likely due to erosion of arterial conduit. Arterial extravasation entered the GI tract via the pancreas transplant at the enteric anastomosis. A covered stent temporized brisk bleeding but was not a permanent solution due to high infection risk. When clinically stable, she underwent transplant pancreatectomy, small bowel resection at the arterio-enteric fistula, and concomitant resection of right CIA and covered stent graft. Paneled saphenous vein graft was used for reconstruction and bare metal stent placed from the R CIA to external iliac artery to ensure adequate flow. She made a full recovery and was discharged home.

Conclusion: Delayed vascular complication following pancreas transplant is rare but potentially life-threatening. Pseudoaneurysm has a reported incidence of 1.4% with rupture and arterioenteric fistula being even more rare. It can occur with both functioning and failed allografts, months to >10 years after transplantation and may be related to inflammation from transplant pancreatitis. Functioning allografts can be salvaged using selective embolization. This unique case of a pancreas transplant with bleeding 10 years later highlights a novel approach to definitive management of the vascular complication that can be addressed without a staged approach allowing for expedited recovery.

