

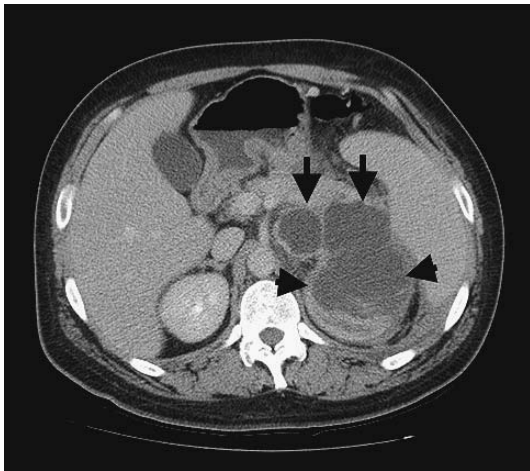
Spontaneous Pancreaticorenal Fistula

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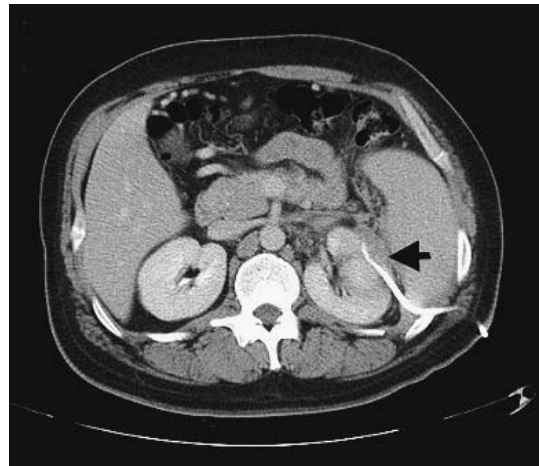
Key words: acute pancreatitis, pancreaticorenal fistula

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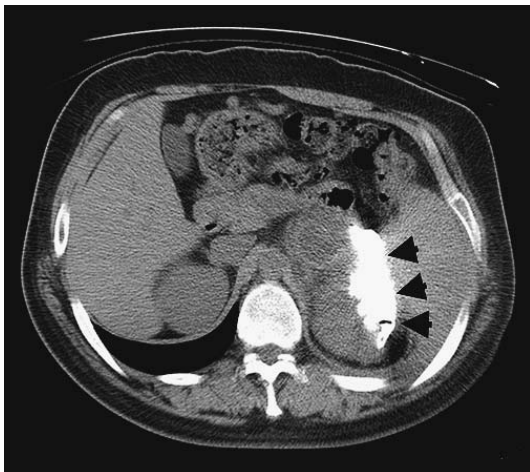
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Picture 1.



Picture 3.



Picture 2.

A 27-year-old diabetic man presented to our hospital with a 2-week history of left flank pain and fever. He had been admitted to our hospital several times due to hypertriglyceridemia-induced acute pancreatitis. Physical ex-

amination showed knocking tenderness in his left costovertebral angle. Laboratory tests showed amylase 391 IU/L and lipase 295 IU/L. Abdominal computed tomography (CT) demonstrated multiple lobulated fluid collections in the region surrounding the pancreatic tail (Picture 1, arrows). A fluid collection in the left anterior perirenal space compressing the left kidney was also identified (Picture 1, arrowheads). CT-guided percutaneous drainage from the left perirenal cyst yielded cola-colored fluid with an amylase of 56,870 IU/L. The prone CT showed contrast medium draining from the left perirenal cyst to the pancreatic pseudocysts (Picture 2, arrowheads). Therefore, a diagnosis of pancreaticorenal fistula was made. Follow-up CT 3 weeks later showed resolution of the pancreaticorenal fistula with thickening of the left kidney (Picture 3, arrow).

Pancreatic pseudocyst extending into the renal subcapsular space is termed as pancreaticorenal fistula. The incidence of pancreaticorenal fistula is extremely rare and usually occurs in the left kidney. The main reason is that the collection must spread not only to Gerota's fascia but also to the renal capsule (1). Moreover, the duodenum offers protection

against spread to the right kidney (2). Most reported cases of pancreaticorenal fistula have a history of alcohol consumption. In the present case, the pancreaticorenal fistula was induced by hypertriglyceridemia-related acute pancreatitis.

Acknowledgement

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