Dear editor,

A 46-year-old man underwent endoscopic ultrasound (EUS)-guided transgastric drainage with subsequent direct endoscopic necrosectomy (DEN) for an infected walled-off pancreatic necrosis (WOPN) which was a complication of a hypertriglyceridemia-induced severe acute pancreatitis. Following treatment, he improved clinically with resolution of fever and substantial reduction in size of the WOPN. He was discharged with indwelling plastic stents which were to be removed after complete resolution of the WOPN (Fig. 1 A to F). Unfortunately, follow-up CT and EUS 1 months later showed spontaneous stents dislodgement and a residual pancreatic fluid collection (PFC) measuring 4.0×2.3cm, for which re-intervention was technically demanding due to the small size (Fig. 1 G and H). As he was asymptomatic, a decision was made to manage him expectantly for spontaneous resolution of the residual PFC. However, against our expectation, 1 year later he presented with recurrent fever to 40.1 °C. An hepatic abscess was identified on CT
scan, which also revealed the residual PFC, though it was further reduced in size (Fig. 1 I and J). After one month of antibiotic treatment, follow-up CT revealed that the hepatic abscess had resolved (Fig. 1 K). Concurrently, complete resolution of residual PFC was also observed (Fig. 1 L).

**Discussion**

EUS-guided drainage/debridement is a first-line therapy for WOPN (1). Remnant PFC due to premature stent dislodgement may persist as an insidious source of infection in which dormant pathogens may become reactivated sometime and culminate in a flare-up. Since the venous drainage of the pancreatic region ends up in the portal vein, occurrence of the hepatic abscess in the presence of the residual PFC should be considered as causal rather than coincidental. At least we couldn’t help arousing a high suspicion of their cause-and-effect relationship. Therefore, despite its being technically challenging, timely reintervention with measures such as EUS-guided needle puncture and irrigation so as to thoroughly eradicate the residual PFC burden should be advocated to reduce the likelihood of late on-set local or distant infection.

**Conflict of interest**

The authors declare no conflict of interest.

**Informed consent**

Informed consent was obtained from the patient for publication of his information and imaging.

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**Reference**


Fig. 1 A. Computed tomography (CT) showing a walled-off pancreatic necrosis with air bubbles inside. B to E. Endoscopic ultrasound guided transgastric drainage followed by direct endoscopic necrosectomy. F. Endoscopic view showing 2 transmural indwelling stents at discharge. G and H. Follow-up CT (arrowhead) and endoscopic ultrasound 1 month after discharge showing residual pancreatic fluid collection (PFC). I and J. CT scan at the onset of fever 1 year later showing hepatic
abscess and residual PFC (arrow). K and L. CT scan after antibiotic treatment showing resolution of both hepatic abscess and residual PFC.