In the past, it became a standard of care that pseudocysts greater than 6 cm or those that are enlarging on serial imaging or become symptomatic warrant drainage. Studies by Mike Sarr and Charles Yeo showed that asymptomatic pseudocysts that may develop after an attack of acute pancreatitis, regardless of size, can be managed conservatively (ie, no intervention). Pseudocysts can become infected, and when this occurs, they are best described as an abscess (abscesses require drainage). Pseudocysts can become painful, especially in patients with chronic pancreatitis. Pseudocysts can also cause early satiety and weight loss when their size affects the stomach and bowel. When confronted with a patient who has a symptomatic pseudocyst, whether it is infected or painful, drainage is recommended.

Drainage can be performed via endoscopic, radiologic, or surgical techniques depending on the location of the cyst and the expertise available. No randomized prospective trials have compared these methods. The myriad of size, locations, anatomy, and local expertise make prospective randomized trials difficult.

Surgical drainage of a pseudocyst is possible with a cystgastrostomy or cystduodenostomy if the pseudocyst wall is broadly adherent to the stomach or duodenum. Other procedures include a Roux-en-Y cystjejunostomy or pancreatic resection if the pseudocyst

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**Figure 27-1.** Pseudocyst. This patient was found to have this fluid-filled, walled-off collection 2 months after an attack of acute pancreatitis. She was unable to tolerate normal meals. After developing post-prandial pain and persistent weight loss, endoscopic drainage was performed.

**Figure 27-2.** Pancreatic necrosis. Two weeks after an admission for acute pancreatitis, this patient developed a fever and was found to have this cystic lesion in the pancreas. Although the radiologist wrote that the patient had a pseudocyst, this lesion is pancreatic necrosis. Drainage, if needed, would require surgical intervention due to the solid components in the cyst.