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Case Report Open Acces

Abstract

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varying severity depending on the local and systemic complications [1]. Pancreatitis can be interstitial which is comparatively mild or associated with necrosis. Necrotising pancreatitis are characterised by non-viable pancreatic tissue associated with surrounding fat necrosis. It can be associated with collections that in acute stage are called acute QHFURWLVLQJ FROOHFWLRQV DQG LQ FKURQLF VWDJHV DUH F
Severe acute pancreatitis can involve the surrounding gastrointestinal tract leading to IRUPDWLRQ RI D ¿VWXOD 7KH FDXVHV RI LW FDQ EH WKH GLUH
E\ WKH LQÀDPPDWLRQ RI SDQFUHDV RU GXH WR YDVFXODU W
DUHD RI LQÀDPPDWLRQ ,W PD\ SUHVHQW DV KDHPRUUKDJH RU
(Figure 1) is an extremely rare complication of necrotising pancreatitis. Pseudoaneurysms are another rare set of complications associated with pancreatitis that can occur due to the pancreatic enzymes eroding the surrounding planes [4]. This case involves the simultaneous presence of these uncommon scenarios in a single patient.

tenderness in the le lumbar region with guarding or rigidity. His serum lipase levels were 198 units/L (normal = 13-60 units/L), total leucocyte count was 15,400/cmm (normal = 4,000-10,000/cmm) and hemoglobin levels was 7.4 g/dl (normal=12-16 g/dl). Rest of the blood workup was normal. Initial resuscitation was done with uid and antibiotics. Urethral catheterization was done for monitoring which showed bile stained muddy urine with sediments. e urine cytological examination was suggestive of pus cells and RBCs. Ultrasonography revealed gross septated uid in le hypochondrium, lumbar and iliac regions with echogenic contents and thickened omentum. For further evaluation, a CT scan of abdomen was done which reported necrotic area within body and tail of pancreas involving less than 30% area with multiple hypodense peripherally enhancing collections in anterior pararenasralypoll9 0 0 9 4 payppatient was initially managed conservatively along with total parenteral nutrition and an ultrasound guided pigtail catheterization of supraputic collection to control the intra- abdominal collection. e output through the pigtail catheterization gradually decreased by post admission day 14 with simultaneous improvement of clinical condition. e urine output also became clearer. He was started on enteral feeding. On post admission day 15, the patient developed two episodes of hematemesis. It v decided to proceed with a CT angiography that revealed a wide neck splenic artery pseudoaneurysm (Figure 2) with no extravasation. Urge coil embolization of the artery was done. Postembolization arteriogra showed compete occlusion of the splenic artery pseudoaneurysm (Fig 2) and normal preserved ow into the spleen. e patient was kept under observation and discharged on post admission day 20 a er removal the pigtail catheter which had no output. e patient is currently being followed up in the outpatient department and is doing well.

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(a) (b)

Discussion

Severe acute pancreatitis is a catastrophic event and its complications are associated with high rates of morbidity and mortality. Enteric stulas associated with severe acute pancreatitis are a known entity but a vesicoenteric stula associated with necrotising pancreatitis is an exceedingly exceptional scenario. Literature reports most of the enteric stulas to be colonic and next duodenal in origin and jejunal involvement is a less commonly seen entity [5, 6, 7]. Most of the upper GI stulas close spontaneously [3]. In our case, we took a conservative approach by undertaking a percutaneous drainage of the infected collection along with broad spectrum antibiotics to control sepsis. Since upper GI stulas are associated with severe electrolyte and uid losses, his labs and vitals were closely monitored. He was kept on parenteral nutrition to allow the stula output to reduce. Pseudoaneurysm is also a less known complication of pancreatitis that can be associated with or without an abscess or pseudocyst. ey can occur due to erosion of the vessel wall by pancreatic secretions. e most commonly involved arteries as in this case are splenic artery. e mortality rates of bleeding from such pseudoaneurysms can be as high as 50% but early angiography followed by timely coil embolization helped salvage the patient [8]. A surprising array of complications in this patient of alcohol induced necrotizing pancreatitis made this one of the rst known cases.

References

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