

A Rare Pancreatitic Sequale

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Abstract: A 35 year old male patient, known case of acute pancreatitis presented in emergency as acute abdomen. Serum amylase – 621 IU/L, X ray abdomen erect revealed generalised ileus, USG abdomen revealed ? perforation probably large bowel origin, CT abdomen revealed gangrenous transverse colon. CT angiography revealed partial occlusion at superior mesenteric artery territory. Emergency laparotomy done, gangrenous segment of transverse colon resected and a colostomy created with proximal end with closure of the distal end. Primary closure of the gastric perforation done. colostomy closure with colocolic anastomosis done after 3 months.

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I. Introduction

Acute pancreatitis is an acute condition presenting with abdomen pain usually associated with raised pancreatic enzymes in blood and urine due to pancreatic inflammation. Gangrene in the transverse colon is due to systemic hypotension created by the disease which leads to slowed down circulation and the vessels commonly affected are superior mesenteric artery more than inferior mesenteric artery. Hence thrombus formation and partial occlusion leading to gangrene of the SMA territory. Gangrenous colon with gastric perforation as a sequel of Acute pancreatitis is a rare entity.

II. Case Reports

A 35yr old patient, admitted with complaints of abdominal pain and vomiting for 2 months and fever for 3 day. The patient was apparently normal 2 months back, he suddenly developed constant dull aching pain over upper and central abdomen following consumption of alcohol previous night. History of radiation of pain to the back, increase in intensity over the present 3 days, Relieved on medications initially but not responding to any drugs for the present 3 days. History of vomiting since 2 months, vomitus contains undigested food particles, non – bilious, not blood stained. History of fever with chills and rigor since 3 days. History of abdominal distention and loose stools present. He is a known case of **pancreatitis** since 2 months, On irregular treatment in private hospital since 2 months. On general examination patient was Conscious and oriented, febrile, pallor +, tachypnoea +, dehydration ++, no pedal edema, not icteric. Blood pressure-90/60 mmhg, Pulse - 110/min, Temp-100 F.

Clinical Picture (Fig 1)



Systemic examination CVS,RS, CNS -normal.

Examination of abdomen

Inspection ,Upper abdominal distention ,
No VIP / VGP, Hernial orifices – free.on **palpation**tenderness present over epigastrium, guarding present over upper abdomen,
no mass or hepatosplenomegaly .on **percussion** No fluid thrill / shifting dullness. On **Auscultation**bowel sounds absent .**PR** – normal

Investigations:

1. Hemoglobin – 9 g%.
2. Sugar - 180mg/dl
3. RFT and electrolytes- urea 60 mg/dl, creatinine – 1.2mg/dl.
4. LFT – normal.
5. Amylase and calcium-631 IU/lit and 8.5 mg/dl.
6. Lipid profile-elevated

Plain X ray abdomen – No air under diaphragm

1. USG abdomen - dilated bowel loops.
2. CT abdomen—possibility of gangrenous transverse colon(splenic flexure) with perforation, focal peritonitis,and partial thrombus of IMA and above intra-renal abdominal aorta.
3. CT angiography – partial occlusion in the superior mesenteric territory
- 4.

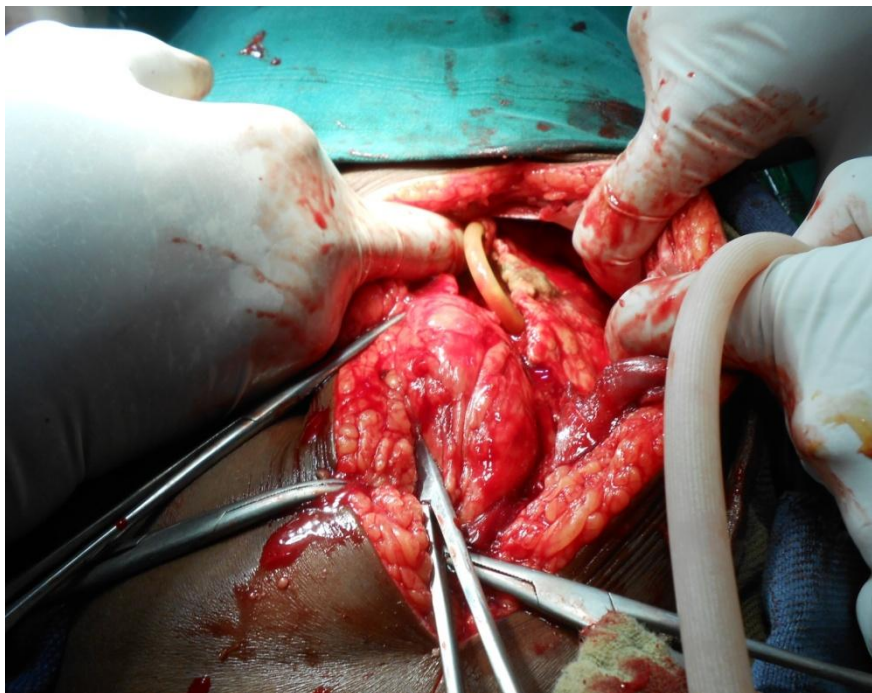
Treatment:

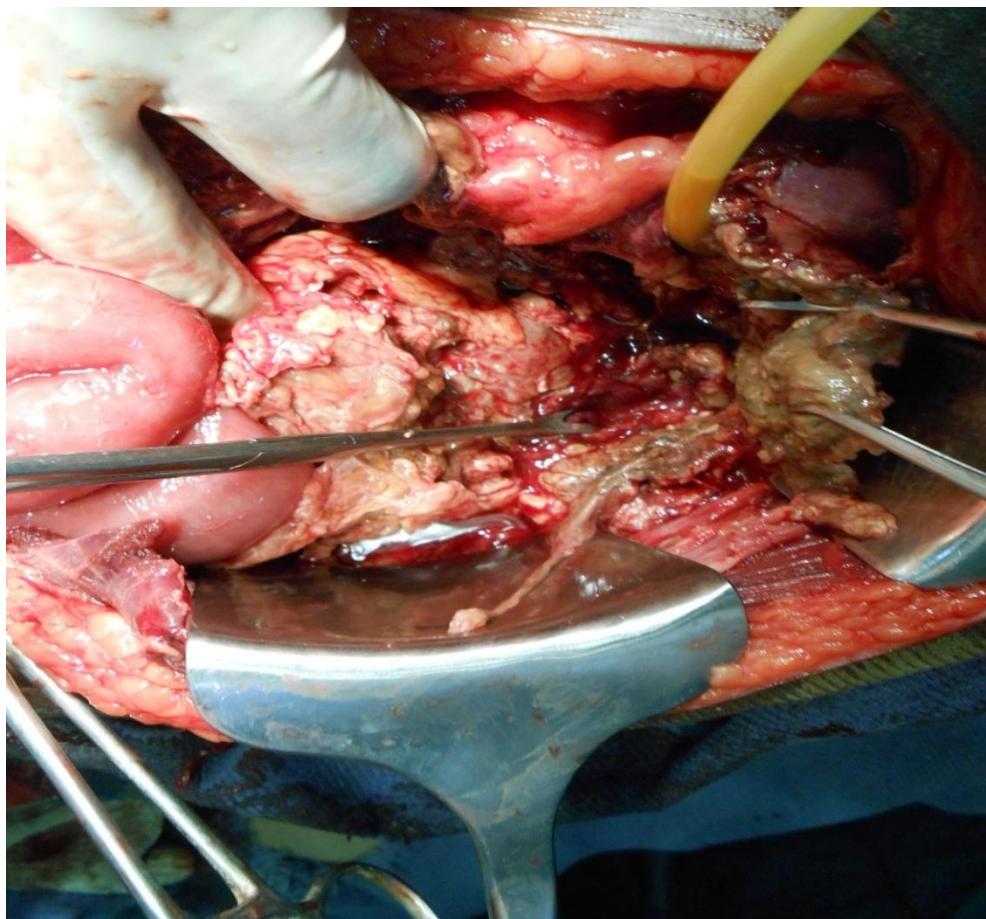
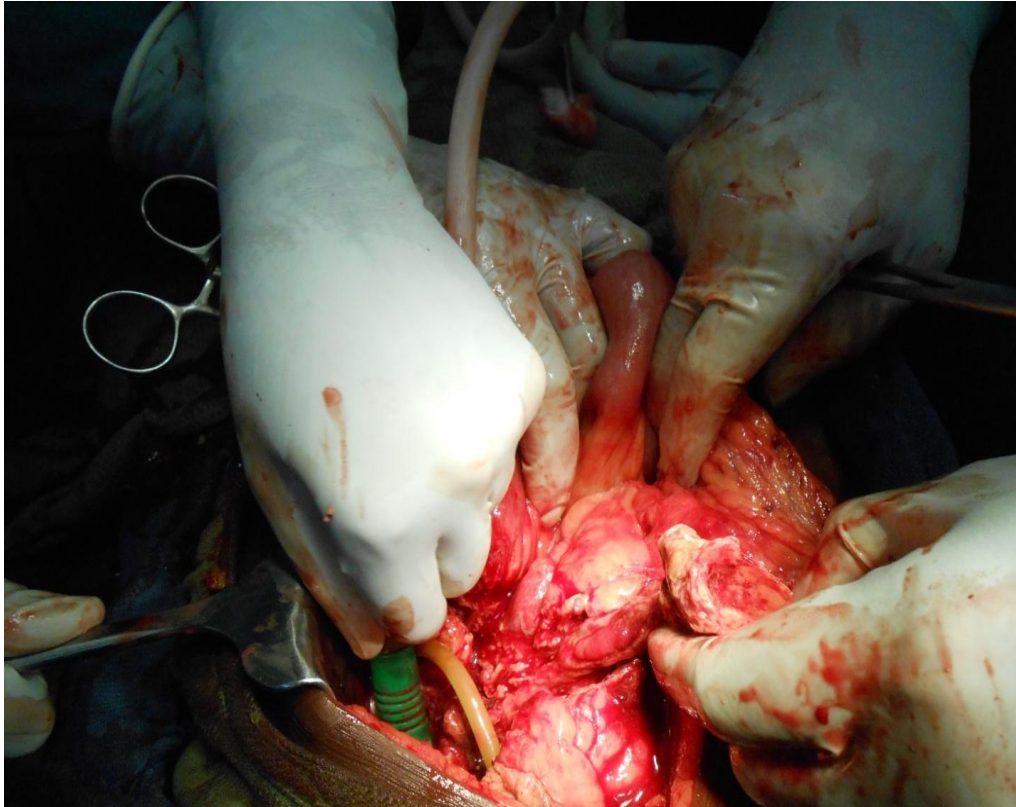
1. Midline incision
2. FINDINGS
3. Abscess in left para-colic gutter and left sub-diaphragmatic space
4. A distal 1/3rd of transverse colon (along with splenic flexure) was sloughed out.
5. Gastric perforation involving the posterior surface .
6. Fluid about 200ml near tail of pancreas.

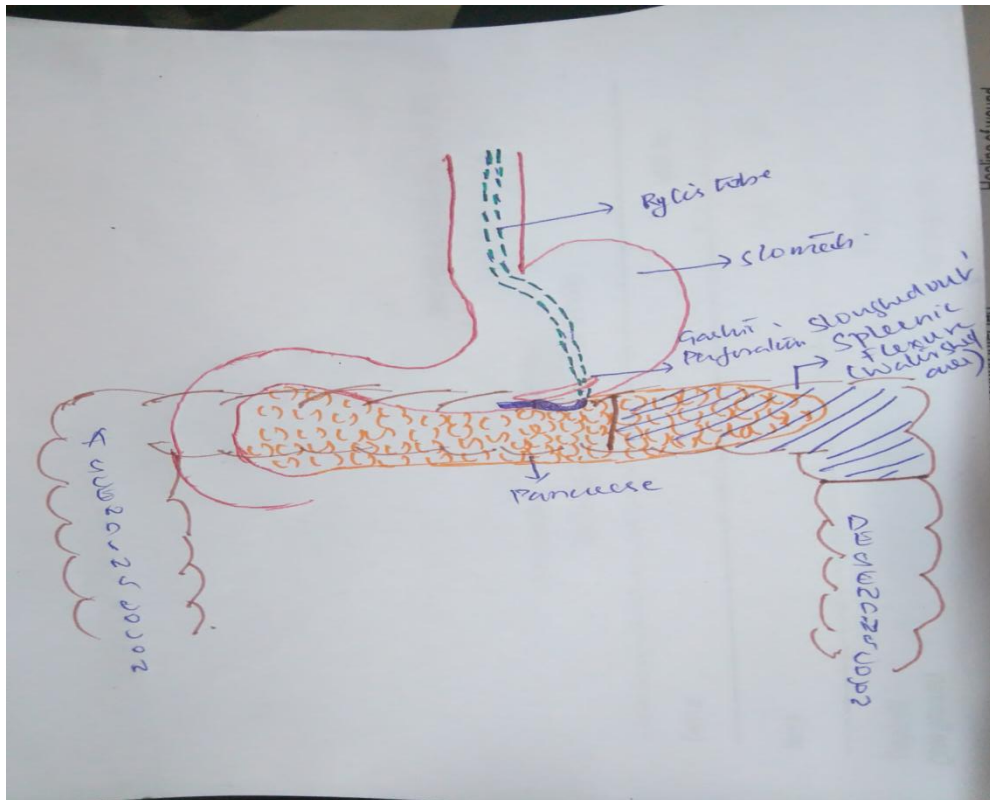
2.1

Procedure

Primary closure of gastric perforation Thorough peritoneal lavage Transverse colon end colostomy of proximal end. Distal end was closed with non – absorbable sutures. Closure of abdomen with intra-abdominal drains.







On FOLLOW UP Post op period was uneventful and he was discharged on 14th POD with good GC. Local examination -Wound healthy ,Colostomy functioning well. Repeat USG abdomen ows normal study



Colostomy Closure was done 3months later ,Colo-colic anastomosis between transverse colon in two layers,Postoperative uneventful

III. Discussion

3.1 Acute Pancreatitis

It Is An Acute Condition Presenting With Abdominal Pain And Is Usually Associated With Raised Pancreatic Enzyme Levels In The Blood And Urine As A Result Of Pancreatic Inflammation.

3.2 Complications

3.3 Acute Pancreatitis :

1. Acute pseudocyst (within > 4wks)
2. Abscess
3. Ascitis
4. Pancreatic necrosis
5. ARF
6. ARDS
7. DIC
8. Hypocalcemia

3.3 Chronic Pancreatitis:

1. Chronic pseudocyst (>6 wks)
2. Pancreatic-enteric fistula
3. Colonic Perforation
4. Erosion into visceral artery
5. Loss of exocrine and endocrine function
6. Pancreatic cancer

3.4 Etiopathogenesis:

1. Pseudocyst and abscess formation (tail of pancreas)
1. Acute mesenteric vascular ischemia/ partial occlusion (due to systemic hypotension)
2. Inflammatory changes and pressure necrosis leads to Bowel gangrene (splenic flexure - watershed **area**) which results in Colon perforation and peritonitis.

3.5 Complications :

1. It occurs in 10 % cases rupture / internal fistulation , bleeding , mass effect Rupture- pancreatic ascites formation , chronic pancreatitis , erosion of splenic , gastroduodenal , splenic and middle coic vessels , pseudoaneurysm formation.

Pancreatic Enteric Fistula :

2. The uncommon entity of pancreato-enteric fistula is produced by spontaneous rupture of a pancreatic pseudocyst or abscess into an adjacent hollow viscus.
3. These fistulas occur between the pancreas and the splenic flexure or transverse colon. Less frequently involved organs include the stomach, duodenum, small bowel, and extrahepatic biliary tree.
4. Treatment Options:
5. Surgery
6. management :
 - a. stomach and duodenum
7. Spontaneous closure
8. If persistent : Surgical correction.
 - a. Transverse Colon
- I. Only surgical correction.

IV. Conclusion

Gangrenous colon with gastric perforation as a sequel of Acute pancreatitis is a rare entity.

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