



**A CASE OF BLUNT TRAUMA ABDOMEN WITH ISOLATED PANCREATIC TRANSECTION – A CASE REPORT**

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**KEYWORDS :**

**Introduction:**

Isolated Pancreatic injuries are uncommon. The mechanism of injury varies according to the age of the patient. The most common mechanism in paediatric patients is abdominal blunt trauma. Direct compression of the epigastrium against the vertebral column and a blunt object (handlebar) is typically seen after bicycle injuries. The most common segment of the pancreas affected is the body. Penetrating injuries into the abdomen are the most common injuries seen in adults. Isolated pancreatic injuries are not common. Up to 90% of patients present with associated hepatic, gastric, splenic, renal, colonic, or vascular lesions. As this is an isolated pancreatic injury made this as a very rare case to present.

**Clinical history:**

A 56yr old Male came with c/o abdominal pain for 4 days duration. Alleged h/o self fall and sustained injury to abdomen 4 days back with dull aching diffuse pain which gradually increased to severe agonizing pain for 4 days which aggravated on taking food and radiating to back. He has history of increase in abdomen distension for 4 days and fever for 3 days and history of obstipation for 2 days.

On examination he is conscious, performance score (ECOG) 2 dehydrated, PR98/min, BP 90/70mmHg. Abdomen distended, diffusely tender, with guarding and no rigidity, bowel sounds absent. Digital rectal examination show normal faecal staining. On performing abdominal x-ray dilated bowel loops were present. CECT abdomen performed showed complete transection of proximal body of pancreas with retraction of fragments and linear fracture of lateral aspect of 9<sup>th</sup> and 10<sup>th</sup> ribs noted.

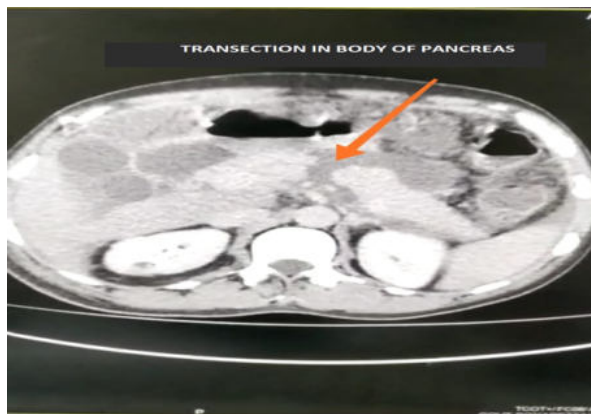


Figure: 1

**Explorative laparotomy done:**

Intra operative findings are haemoperitoneum of about two litres, saponification of transverse mesocolon, mesentery and omentum. Total transection of the body of the pancreas with distal pancreatic atrophy and total duct disruption and

splenic vein thrombosis. Operation was proceeded with distal pancreatectomy with splenectomy was done. Through peritoneal wash was given and drain kept and abdomen closed.

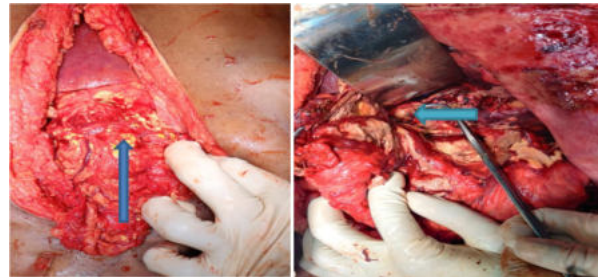


Figure: 2

Figure: 3



Figure: 4

**DISCUSSION:**

Pancreatic injuries are classified according to the system described by the American Association for the Surgery of Trauma.

**TABLE 102.1 American Association for the Surgery of Trauma Organ Injury Scaling: Pancreas**

| Type of Injury   |  |
|------------------|--|
| <b>GRADE I</b>   |  |
| Hematoma         | Minor contusion without duct injury                          |
| Laceration       | Superficial laceration without duct injury                   |
| <b>GRADE II</b>  |  |
| Hematoma         | Major contusion without duct injury or tissue loss           |
| Laceration       | Major laceration without duct injury or tissue loss          |
| <b>GRADE III</b> |  |
| Hematoma         | Distal transection or parenchymal injury with duct injury    |
| <b>GRADE IV</b>  |  |
| Laceration       | Proximal transection or parenchymal injury involving ampulla |
| <b>GRADE V</b>   |  |
| Laceration       | Massive disruption of pancreatic head                        |

Pancreatic trauma continues to carry a significant risk of mortality and morbidity. Therefore treating other injuries to stabilize the patient may be necessary before definitive operative management of the pancreatic injury can occur. Prompt diagnosis, appropriate resuscitation, and careful surgical technique are paramount in the proper treatment of pancreatic trauma. The grade of the injury, and particularly the presence and location of a pancreatic ductal injury,

determines the most appropriate operation (hemostasis, debridement, drainage versus resection, pyloric exclusion, or rarely pancreaticoduodenectomy). Finally, complications are likely to occur, so close observation and early intervention are essential to the recovery of patients with pancreatic trauma.

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