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Original Research Paper

General Surgery

CONCURRENT PRESENTATION OF ACUTE PANCREATITIS AND ACUTE APPENDICITIS IN A PATIENT

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ABSTRACT Appendicitis and pancreatitis are two distinct clinical entities with some similar and some peculiar clinical features and have not been described to be associated with each other usually. Here we present a case report describing the concurrent presence of both these conditions which were managed conservatively.

KEYWORDS : acute appendicitis, acute pancreatitis

INTRODUCTION

Acute pancreatitis and appendicitis are common causes of pain abdomen presenting in the emergency department and may rarely present together.[3] Although both these conditions have peculiar signs and symptoms however there is a sufficient overlap overall in the signs and symptoms of both the diseases. Co-existence of both these pathologies in a patient may suggest appendicitis to be a complication of pancreatitis or could have occurred independent of the latter[1.] We report a case of a 28-year-old male who presented to the emergency department with clinical features of acute pancreatitis and on further investigations was also found to have appendicitis.

Case Report

A 28-year-old gentleman with no known co-morbidities reported to the emergency department with the chief complaints of pain in the epigastric region, which was insidious in onset and gradually progressive, severe aching in nature, not associated with meals, of 3 days duration associated with multiple episodes of non-bilious non projectile vomiting that contained food particles not taken long ago. Patient also had an episode of high-grade fever with chills. Patient was a non-alcoholic and non-smoker with no history of any similar episodes in the past. Clinical examination revealed tachycardia, tachypnoea with tenderness, and guarding all over the abdomen, bowel sounds were heard and per rectal examination revealed normal ano-rectal region with fecal staining around the glove. Blood investigations revealed raised serum and lipase. X-rays of the abdomen revealed transverse colon distension. Ultrasound of the abdomen revealed obscured pancreas due to overlying bowel gases and an inflamed appendix with fluid in the pelvis.

A CECT done with both intravenous and oral contrast revealed ascites in pelvis and paracolic gutters with a dilated appendix with a diameter of 11 mm with an associated appendicoliths, along with mesenteric and omental fat stranding along with fluid in the pelvis and para colic gutters. CT also revealed pleural effusion with underlying basal lung collapse. As previous studies have suggested appendicitis can be treated conservatively and unless incarcerated appendicoliths do not cause failure of non-operative management[5], and that an operative procedure in the presence of pancreatitis would carry sufficient morbidity, the patient was managed conservatively. The pain abdomen decreased in intensity and fever episodes subsided on day 6th of the admission with intravenous antibiotics and fluids along with pain management. Patient was started on liquid diet orally on day 7 and begun on solids on day 9. The patient made an uneventful recovery and was discharged on day 10 and was dated for an interval appendectomy later.

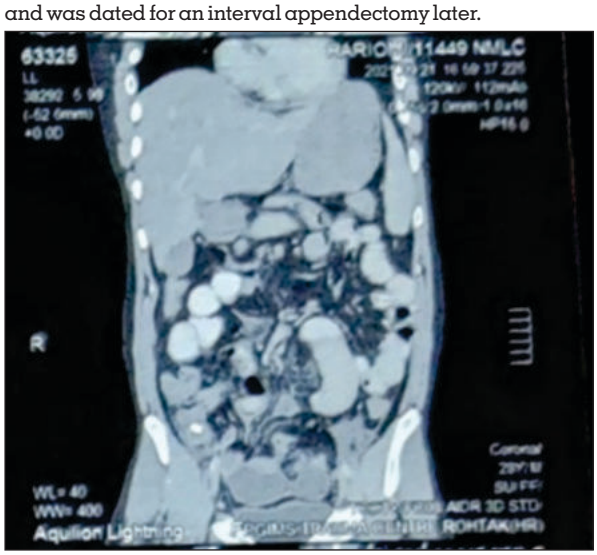

Fig 1. CT Scan Depicting Appendicitis With Appendicolith

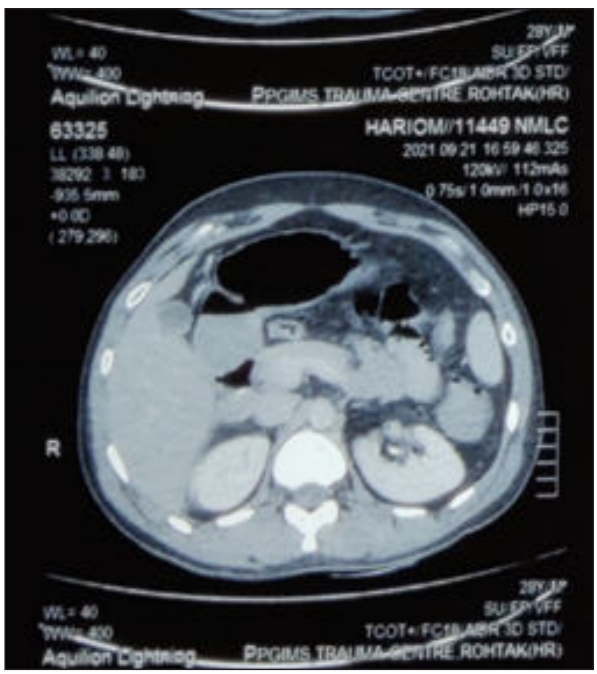

Fig 2. CT Scan Showing Acute Pancreatitis

DISCUSSION

Clinical symptoms and signs of pancreatitis can hide the features of appendicitis, a serum amylase though is raised in both these conditions, its levels, as suggested by previously conducted studies, has a modest rise in appendicitis[6] but can increase triple fold or more in pancreatitis[7] and is in-sensitive to the underlying pathology as it can rise in a myriad of other conditions[8]. Pancreatitis can specifically be predicted by an increase in serum lipase levels[9]. Presence of pain fever vomiting, and anorexia can occur in both these conditions[9,10]. A tense abdomen and guarding abdominal muscles as in seen in pancreatitis can hide the signs of appendicitis and since most of the large gut complications that do occur in pancreatitis, happen to the transverse colon[9] hence while treating a patient with pancreatitis a lower level of suspicion is maintained when it comes to appendicitis. Tenderness in the right iliac fossa can occur in pancreatitis as part of the picture of abdominal signs, Pancreatitis leading to appendicitis has been suggested by a couple of previous reports which on histopathological evaluation showed inflammation of the peri-appendiceal tissue[2,11], so is the independent presence of both these conditions[1,3]. In our case report the patient had simultaneous presence of both pathologies hence a discrete clinical correlation cannot be decided upon, as to which led to the other or whether these were isolated clinical events. It is agreeable however to postpone the operative management of appendicitis in presence of pancreatitis considering the morbidity that may ensue after appendectomy.

CONCLUSION

In conclusion we would like to say that although rare, appendicitis and pancreatitis can occur together as dual pathologies of the abdomen. Although in presence of a pancreatitis, appendicitis may not have a clear path for diagnosis, a CECT is indeed helpful in detecting the pathology and any complication arising out of it. Both these conditions can be managed conservatively together, with an interval appendicectomy reserved for later or emergency appendicectomy on failure of non-operative management or for any complication arising thereof.

REFERENCES

1. Alaqqad, M., Ram, L., Kannan, P., & Abou Al Neaj, M. (2015). Pancreatitis complicated by acute appendicitis. *Hamdan Med J*, *8*, 161-4.
2. Nozari, N. (2016). Appendicitis as a complication of acute pancreatitis; A case report. *Govaresh*, *21*(3), 199-201.
3. Kukreja, M., Choudhary, Chawla and Srivastava, 2022. *Dual Pathology of Acute Pancreatitis and Acute Appendicitis in a patient presenting with Acute Abdomen*. [online] Worldwidejournals.com. Available at: <https://www.worldwidejournals.com/global-journal-for -research-analysis-GJRA/article/dual-pathology-of-acute-pancreatitis-and-acute-appendicitis-in-a-patient-presenting-with-acute-abdomen/MTM1MTk=/>
4. Forster, M. J., & Akoh, J. A. (2008). Perforated appendicitis masquerading as acute pancreatitis in a morbidly obese patient. *World Journal of Gastroenterology: WJG*, *14*(11), 1795.
5. Kohga, A., Kawabe, A., Yajima, K., Okumura, T., Yamashita, K., Isogaki, J., ... & Muramatsu, K. (2021). Does the presence of an appendicolith or abscess predict failure of nonoperative management of patients with acute appendicitis?. *Emergency Radiology*, *28*(5), 977-983.
6. Amanollahi, O., & Tat, S. (2018). The study of diagnostic value of elevation of serum amylase as a predictive factor for appendiceal perforation in children with acute appendicitis. *International Journal of Pediatrics*, *6*(2), 7213-7217.
7. Winslet, M., Hall, C., London, N. J., & Neoptolemos, J. P. (1992). Relation of diagnostic serum amylase levels to aetiology and severity of acute pancreatitis. *Gut*, *33*(7), 982-986.
8. Salt 2nd, W. B., & Schenker, S. T. E. V. E. N. (1976). Amylase--its clinical significance: a review of the literature. *Medicine*, *55*(4), 269-289..
9. Munoz, A., & Katerndahl, D. A. (2000). Diagnosis and managment of acute pancreatitis. *American family physician*, *62*(1), 164-174..
10. Petroianu, A. (2012). Diagnosis of acute appendicitis. *International Journal of Surgery*, *10*(3), 115-119.
11. Hsia, H. C., Shoung, L. K., Chen, M. L., & Wong, D. W. (2002). Acute pancreatitis complicated with periappendicitis. *Zhonghua yi xue za zhi= Chinese medical journal; Free China ed*, *65*(12), 619-621.