Original Research Paper

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General Surgery

A CASE OF BLUNT ABDOMINAL TRAUMA WITH ISOLATED PANCREATIC INJURY

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KEYWORDS :

INTRODUCTION

As pancreas is retroperitoneal organ, it is not frequently damaged in blunt abdominal trauma. Occasionally a forceful compression to epigastrium may crush parts of pancreas against vertebral column Pancreatic injuries may range from a contusion or lacerations of parenchyma without duct disruption to major parenchymal destruction with duct disruption and rarely massive destruction of pancreatic head.

CASE REPORT

A 24 year female patient present with H/o RTA having blunt abdominal trauma with c/o severe epigastric pain and 2-3 episodes of vomiting Abdominal pain was sharp, severe and radiating to back.

N/H/O fever, hemetemesis, malena, hematuria.

Investigations

CXR and AXR: NAD Serum amylase and serum lipase elevated to more than 2000.

USG (A+P): Pancreas obscured, mild free fluid with echoes in peritoneal cavity.

CECT (A+P): Blooddense area of size 23*22*20mm involving neck and body s/o pancreatic laceration. Pancreatic duct not visualized distinctly p/o pancreatic duct injury. S/o: **AAST grade 3 injury-** Distal transection or pancreatic parenchymal injury with ductal injury.

MRCP: Presence of collection of size 15*24mm in pancreatic neck region. Absence of flow in pancreatic duct through its extent. Findings s/o pancreatic laceration with pancreatic duct injury.

Management

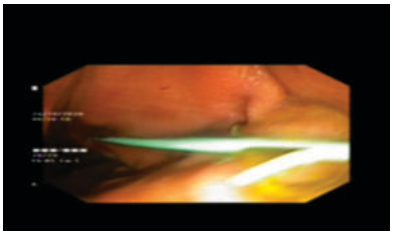
Patient was initially managed conservatively. For feeding, UGI scopy guided NJ tube insertion was done and was kept in-situ for 1 month.

Patient had intermittent abdominal pain and steatorrhea for next two months with persistently elevated amylase and lipase levels and CECT s/o similar findings as previous one. ERCP done with pancreatic duct stenting. After 12weeks PD stent removed and MRCP examination findings s/o chronic pancreatitis with stricture in pancreatic head region.

EUS guided PANCREATOGASTROSTOMY done over stent.

5 Fr *10cm straight plastic PD stent placed in MPD to stomach via body and tail Drainage of pancreatic juice in stomach noted.

Patient discharged without any further complications and with improvement of symptoms of diarrhea and abdominal pain.



Photos.

Plastic stent after pancreatogastrostomy.Showing free flow of pancreatic juice. In stomach.

X-ray showing PD stent from Body and tail of pancreas to Stomach.

DISCUSSION

Pancreatic trauma is rare and associated with injury to other abdominal viscera. The modality of choice to evaluate abdominal trauma is CT-Scanning ofabdomen.

Findings such as pancreatic hematoma, free fluid in lesser Sac, and thickening of gerota fascia s/o pancreatic injury The most reliable test to demonstrate pancreatic duct integrity is ERCP but its applicability is limited by risk of inducing pancreatitis.

Studies have shown that MRCP provides excellent visualization of pancreatic duct. Most pancreatic lesions can be temporarily controlled with drains. Once the physiological insult has been controlled, definitive treatment should be considered if indicated.

Non-operative management is safe for low grade injuries and many selected high grade injuries especially in children and young adults. For high grade injuries, ERCP can also be therapeutic with pancreatic duct stent placement.

In some high grade injuries with MPD disruption or other penetrating injuries operative procedures may required such as pancreatico-duodenectomy or pancreatico-jejunostomy.

CONCLUSION

The diagnosis of pancreatic trauma requires a high index of suspicion and detailed imagine studies. Grading of pancreatic injuries is important guide for operative management. Most important prognostic factor is pancreatic duct disruption.

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