Original Research Paper

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Gastroenterology

AN INTERESTING CASE OF ASCITES

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ABSTRACT This is a case of middle aged female presented with abdominal distension and pedal edema with symptoms of anemia, exocrine and endocrine dysfunction of pancreas, and denovo diagnosed diabetic, with history of old pulmonary tuberculosis, upon investigating came to be as chronic atrophic pancreatitis with exocrine and endocrine dysfunctions with complications of splenomegaly, hypersplenism, esophageal varices, and portal biliopathy.

KEYWORDS :

CASE REPORT:
A 40 yr female, coolie by occupation, came with chief complaints of

- Abdominal distension for 5 days
- Swelling of both foot for 5 days

Patient developed abdominal distension from 5 days which is insidious in onset and gradually progressive associated with mild pain. Swelling of both foot from 5 days which is insidious in onset, gradually progressive and finds tightness in wearing chappals with marks over foot.

H/o easy fatigability and palpitations on exertion, increased frequency of urination, increased thirst, not gaining weight inspite of increased apatite, with bulky, greasy, large quantity stools associated with foul smell.

No h/o fever, cough, cold, breathlessness, chest pain, dizziness, syncopal attacks, PND, orthopnea, decreased urine output, burning micturition, frothy urine, vomiting, loose stools, blood in vomiting and stools, black color stools, yellowish discoloration of eyes and urine, and excessive itching.

Patient was diagnosed as pulmonary tuberculosis 4 months back and used ATT for 1 month and then discontinued Not a known diabetic, hypertensive, CKD, CHF, seizure disorder, No h/o fever, cough, chest pain, abdominal pain and any significant complaints in the past, No alterations/disturbances in sleep pattern, bowel and bladder disturbances, No similar complaints in the family members and nil significant, No menstrual irregularities, No significant treatment history in the past apart from usage of ATT for 1 month.

General examination:
Pallor and pedal edema present, No jaundice, cyanosis, clubbing, lymphadenopathy, No signs of liver cell failure and tubercular skin manifestations with normal pulse, blood pressure recordings, and normal JVP.

Investigations:
High initial blood sugar levels, Hb : 5.2 g/dl, Wbc : 3000 cells/mm3, Plt : 75000 cells/mm3, S creatinine : 0.7 mg/dl, Bl urea : 24 mg/dl, T.bil :2 mg/dl, D. bil : 1.5 mg/dl, Alt : 24 u/dl, Ast : 28 u/dl, Alp : 151 u/dl, T.prot : 6.3 g/dl, S alb : 3.6 g/dl, ESR: 110 mm/hr, S.amylase**:** 92, S.liphase**:** 105, Thyroid profile : normal, Normocytic normochromic anemia with leucopenia and thrombocytopenia

USG abdomen: Regular surface with normal echotexture of liver, Moderate splenomegaly with portal cavernoma

Ascitic fluid analysis: Proteins: 0.5 g/dl, serum albumin: 4.5 g/dl, Ascitic Albumin: 0.4 g/dl, Glucose : 260 mg/dl, cells : 120 with 90% lymphocytes, ADA : 3.3, SAAG 2.7 (high saag low protein)

CECT abdomen: Normal liver with moderate splenomegaly, Portal cavernoma and tiny thrombus in distal superior mesenteric vein, Atrophic pancreatitis with dilated main pancreatic duct, Moderate ascites, Multiple portal collaterals at porta hepatis, tapered distal CBD with upstream dilation.

Upper GI endoscopy: Grade 3*2, 2*1 columns of esophageal varices present

DISCUSSION:

- Up to 20% of people with chronic pancreatitis do not have any pain.
- Symptoms of endocrine and exocrine deficiencies usually do not develop until the pancreas looses about 90% of its function.
- Alcoholic chronic pancreatitis: exocrine insufficiency after 16yrs, endocrine insufficiency after19-20yrs.
- Idiopathic chronic pancreatitis: endocrine insufficiency after 11yrs, endocrine insufficiency after 13yrs.
- A small amount of ascites is seen in 10-20% of patients with chronic PVT who do not have cirrhosis, after GI bleed due to dilutional hypoalbuminemia.
- Around 6-10% of patients with acute pancreatitis develop PVT, where as 10-15% of patients with chronic pancreatitis develop PVT.
- TB involves peritoneum, stomach, intestinal tract, hepatobiliary tree, pancreas, perianal area, lymph nodes.
- Most commonly ileocecal area 25-90%, colon 2-32%, peritoneum 6.5%, gastroduodenal area 0.5-5%
- Uncommon forms of abdominal TB include involvement of stomach (rare), pancreas (rare), spleen (rare)

CONCLUSION:
Although patient had no specific symptom of pain abdomen for pancreatitis she developed chronic atrophic pancreatitis with both exocrine and endocrine deficiencies with complication of extra hepatic portal venous obstruction, splenomegaly, hypersplenism, esophageal varices, portal biliopathy with out hepatic extinction. With etiology being idiopathic or tuberculosis or autoimmune. There is limited evidence and studies based on this clinical scenario.

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