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PANCREATIC TRANSECTION DUE TO BLUNT TRAUMA: A CASE REPORT

General Surgery

Rajiv R Junior Resident, Department of General Surgery, K. S. He gde Medical Academy, Deralakatte, Mangalore.

Nawin K* Associate Professor, Department of General Surgery, K.S Hegde Medical Academy, Deralakatte, Mangalore.*Corresponding Author

ABSTRACT

Transection of pancreas is rare in cases of blunt trauma. Here we are presenting a 40-year-old male who presented to casualty with an alleged history of fall of stone over his body. His vitals were stable. There was diffuse tenderness all over the abdomen and guarding was present. CECT abdomen and pelvis revealed significant pneumoperitoneum with moderate intraperitoneal free fluid with possibility of Proximal jejunal injury. Patient was posted for Emergency laparotomy. Around 2.5 litres of blood mixed with bile and bowel content noted in the peritoneum. Complete transection of the DJ flexure and partial transection of pancreatic tail was noted. Small bowel was anastomosed in 2 layers. Pancreatic tail was removed and pancreatic duct patency was preserved by passing a 6 fr Infantile feeding tube through the duct draining to the duodenum. Drains were removed on POD-11. There was a SSI on POD-5 and gaping developed over the abdominal site. Secondary suturing was done on POD-22. FJ was removed on POD-36. Patient recovered well and is coming for regular followup.

KEYWORDS

INTRODUCTION

Transection of Pancreas is rare in cases of blunt trauma. Often physical signs and laboratory parameters can be inaccurate. This case is a reminder that pancreatic injuries should be considered in the differential diagnosis in cases of blunt abdominal trauma.

CASE REPORT

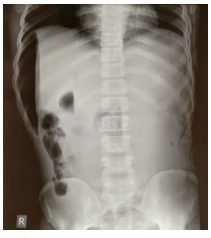
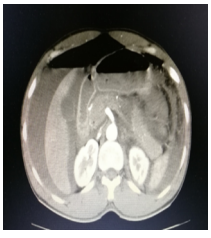
A 40 year old male presented to ER with an alleged history of fall of stone over his abdomen with abrasions over face, chest and abdomen and a lacerated wound over the right fore arm. Patient had complaints of abdominal pain. There was no history of loss of consciousness, seizures, ENT bleed, vomiting or difficulty breathing. On examination, patient was conscious, co-operative and well oriented to time, place and person. Patient was moderately built and nourished. Pulse of 69 beats per minute and BP of 100/80 mm of hg, SPO2 – 100% on Room air, GCS – 15/15. There was pallor present. Per-abdomen – generalised guarding and rigidity present, shifting dullness present. 10x3 cm contusion in right hypochondrium noted. Abdominal girth – 70 cm. Bowel sounds were sluggish. External genitalia- normal, Per-rectal – sphincter tone normal.

INVESTIGATIONS

Hb- 13.2, TLC–10,300, INR–1.15, Creatinine–1.52, Blood Urea –40.3
FAST scan – Showed free fluid in all 4 quadrants of the abdomen with no sign of solid organ injury.

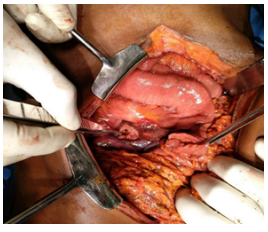
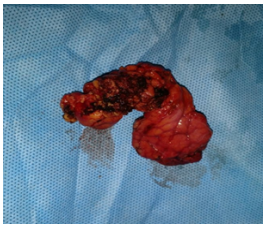
Left lateral decubitus X-ray of abdomen - Air under the right hypochondrial region

CECT Abdomen pelvis - Significant pneumo-peritoneum. Moderate intraperitoneal free fluid. Small grade – I laceration in segment V of right lobe of liver. Fluid collection with free intraperitoneal air in the region of lesser sac of stomach near the DJ flexure.

Treatment

Patient was posted for emergency laparotomy. A midline incision was made and peritoneum entered. Around 2.5 litres of blood mixed with bile and bowel contents noted in the peritoneum. Complete transection of DJ flexure and partial transection of pancreatic tail was noted. Small bowel was anastomosed in 2 layers. Pancreatic tail was removed and pancreatic duct patency was preserved by passing a 6 fr infantile feeding tube through the duct draining into the duodenum. A nasogastric tube was placed past the anastomotic site and fixed. A feeding jejunostomy was placed to provide nutritional support post-operatively.

DISCUSSION

This case report shows that the diagnosis of a pancreatic transection can be difficult at first. Trauma to the pancreas is not common as the pancreas lies retroperitoneal. But due to its location being anterior to the vertebral column, it may get compressed against the vertebral body. Injury to pancreas is frequently combined with injuries to the other organs, particularly the duodenum and this may cause early death of the patient. Pancreatic injury maybe missed or the diagnosis maybe delayed because the initial symptoms and signs of pancreatic injury are subtle and this may contribute to the morbidity and mortality associated with the injury.

CONCLUSIONS

Suspecting a possible pancreatic injury after blunt abdominal trauma is important. As in our case the timely response and immediate intervention has proven very effective.

REFERENCES

1. Ankouz, A., Elbouhadouti, H., Lamrani, J., Taleb, K. A., & Louchi, A. (2010, January 4). Pancreatic transection due to blunt trauma. Retrieved March 9, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2823149
2. O'Hanlon, D. M., Shaw, C., Fenlon, H. M., & McEntee, G. P. (2002, February 5). Traumatic transection of the pancreas. Retrieved March 9, 2020, from https://www.ncbi.nlm.nih.gov/pubmed/11918886