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# A RARE CASE OF ACUTE NECROTIZING PANCREATITIS IN EARLY POSTPARTUM PERIOD IN A PRIMIGRAVIDA

Emergency Medicine

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## ABSTRACT

Acute pancreatitis in pregnancy is rare, with the incidence being 3 in 10,000 pregnancies. Its occurrence is of great concern to clinicians as they are dealing with two lives and increased incidence of morbidity. Here, we report case of a 24 yrs. old P1L1(Parity1, Living 1) post LSCS (lower segment caesarean section), day 2. Brought to Emergency room (ER) GMCH Miraj with c/o of, sudden onset breathlessness, she had emergency caesarean section at previous hospital which went uneventful & gave birth to baby girl (35weeks & 2days).

## KEYWORDS

Pancreatitis, Postpartum, Emergency Caesarean Section

## INTRODUCTION

Acute pancreatitis during pregnancy is a rare life-threatening clinical problem with variable incidences, can occur during any trimester but around 52% of cases are found in the third trimester. Acute pancreatitis is triggered by activation of pancreatic trypsinogen followed by auto-digestion which leads to cellular disruption, proteolysis, edema, hemorrhage and necrosis.[1,2] Cholelithiasis is the commonest etiology for acute pancreatitis in pregnancy.[3]

The most common presentations of the condition include low-grade fever, nausea, vomiting, anorexia, mid-epigastric pain, left upper quadrant pain radiating to the left flank and decreased bowel sounds. A multidisciplinary team consisting of a surgeon, radiologist, obstetrician, and a neonatologist should be available, though the strategy for treatment is similar to the general nonpregnant patient with acute pancreatitis.[4] Hence, we report a rare case of acute necrotizing pancreatitis in early postpartum period in a primi.

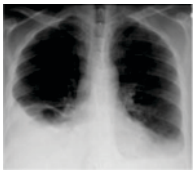
### Case Presentation

A 24 yrs. old P1L1 post LSCS (day 2) brought to ER GMCH Miraj with c/o of, sudden onset breathlessness, she had emergency caesarean section at previous hospital which went uneventful & gave birth to baby girl (35weeks & 2days). No h/o DM, No h/o Hypertension. At Triage evaluation, patient was conscious, oriented, tachypnic 40/min, tachycardia-152/min was present with increased blood pressure 150/100 mmhg. Her saturation was 90% on room air.

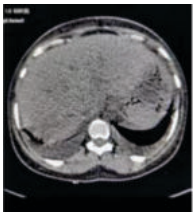
### Physical Examination

Temperature : 38°C
Pulse : 152 /min
RR : 40 / min
BP : 150/100mmHg
SPO2 : 90% on room air

**Airway-** Patent, patient was able to phonate
**Breathing-** Spo2-90% on room air, RR-40/min, B/L air entry decreased. Patient was put on High Flow o2 therapy- NRBM
**Circulation-** Pulse Rate - 152/min,
**Blood Pleasure -** 150/100mmHg
**Disability-**E4V5M6, Pain at epigastric region, dull, continuous, non radiating not associated with vomiting no aggravating nor relieving factors On Numeric Pain Scale-4/10= analgesics given.
**Exposure-** clean caesarean scar at lower abdomen.



**Chest X-ray PA View Revealed B/L Mild Plural Effusion On Lung Fields.**



**CT Scan Of The Abdomen Revealed Enlarged Pancreas With Necrotic Changes In Body And Tail With Moderate Ascitis.**

### Hospital Course & Management

- As x-ray chest s/o B/L plural effusion- pt initially put on high flow o2 and as her spo2 increased to 94% her respiratory rate came to 35/min, patient shifted to EM ICU.
- ECG s/o sinus tachycardia (we were thinking of postpartum cardiomyopathy but no hypotension, normal JVP, no low voltage qrs.
- Later we got CT abdomen s/o acute necrotizing pancreatitis with mod ascitis.-started to treat as pancreatitis with broad spectrum antibiotics, analgesics and iv fluids @100ml/hr.

## DISCUSSION

The management of acute pancreatitis during pregnancy poses a dilemma. It is usually self-limiting but can occasionally progress to severe disease and even death. The knowledge of the signs and symptoms along with the management of this condition is of prime importance so that the risk of mortality of the mother and fetus can be reduced.

The clinical characteristics of acute pancreatitis in pregnancy are similar to the nonpregnancy state. The usual symptoms seen are abdominal pain, anorexia, nausea, vomiting, dyspepsia, low-grade fever, tachycardia, fatty food intolerance. Leukocytosis, increase in the inflammatory and pancreatic markers and in case of biliary disease rise of cholestatic markers can be seen on hematological and biochemical examination.[5] But, a diagnosis of acute pancreatitis is made only after a thorough investigation since the hematological, biochemical and clinical findings are also seen in the nonpregnant state. Though acute pancreatitis is more commonly seen in the 2nd and 3rd trimesters, it can also occur in the 1st trimester.[6]

Acute pancreatitis can be diagnosed based on the presence of two or more of the three criteria seen: (1) abdominal pain consistent with pancreatitis, (2) serum amylase and lipase increased to more than three times the normal values and (3) characteristic findings suggestive of acute pancreatitis seen on the USG or CT or MRI.[7] A crucial role is played by the serum biochemical markers in identifying the condition early and leading to prompt treatment—amylase and lipase. There is a rise within the first 12 hours after the onset of symptoms and returns to

normal within 3 to 5 days in the case of serum amylase.[8] Serum lipase activity remains increased for longer (up to 8-14 days), and is of increased sensitivity in patients with a delayed presentation. Hence, lipase is considered to be diagnostically accurate than amylase.[9]

The imaging techniques in use today form a more accurate picture of the condition of acute pancreatitis and hence they are to be used to make a complete clinical diagnosis.

The commonly used imaging techniques are ultrasonogram, CT, MRI, magnetic resonance cholangiopancreatography (MRCP) and endoscopic retrograde cholangiopancreatography (ERCP). The safest mode of imaging used for diagnosis is the transabdominal ultrasound as there is no danger of emitting harmful radiation to the fetus.

Computed tomography is the most efficient imaging technique as it is used for confirming the diagnosis, classifying pancreatitis in interstitial edematous or necrotizing, depicting the local complications and also for defining the severity of the disease. Computed tomography is now used only where severe acute pancreatitis is suspected as mild pancreatitis does not require any intervention.

## CONCLUSION

While a rare event, acute pancreatitis does occur in pregnancy and remains a challenging problem to diagnose and manage.

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