



ORIGINAL RESEARCH PAPER

Medicine

ACUTE PANCREATITIS: AN ATYPICAL PRESENTATION

KEY WORDS:

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ABSTRACT Pancreatitis is a condition associated with local and systemic complications. Painless pancreatitis is very rare. Here we are presenting a case of painless pancreatitis. 92 yrs old lady with no comorbidity admitted with features of intestinal obstruction. Investigations revealed high amylase and lipase level. CT scan of abdomen confirmed the diagnosis of acute pancreatitis.

Introduction

Acute pancreatitis (AP), an inflammatory disorder of the pancreas, is the leading cause of admission to hospital for gastrointestinal disorders in the USA and many other countries^[1]. The diagnosis of AP requires 2 of the following 3 features: (1) abdominal pain characteristic of AP, (2) serum amylase and/or lipase ≥ 3 times the upper limit of normal, and (3) characteristic findings of AP on CT scan^[2]. During AP, serum lipase increases within 4–8 h, peaks at 24 h, and remains elevated for 1–2 weeks, with a half-life between 7 and 14 h^[3]. Lipase is more sensitive and specific than amylase in diagnosing AP, with a negative predictive value of 94–100%^[4]. Most patients with AP experience abdominal pain that is located generally in the epigastrium, and radiates to the back in approximately half of the cases. The onset may be swift with pain reaching maximum intensity within 30 min, frequently unbearable, and characteristically persisting for more than 24 h without relief. The pain is often associated with nausea and/or vomiting^[2]. We are reporting here a case of acute pancreatitis with atypical presentation.

92 yrs old lady nondiabetic, nonhypertensive admitted with nausea and vomiting without any pain abdomen. History of no bowel movement for last few days before admission. No history of alcohol intake or drug abuse. No history of abdominal trauma. On physical examination, she was febrile, had a heart rate of 108 beats/min, and a blood pressure of 132/84 mm Hg. Abdomen was distended with sluggish intestinal peristaltic sound. The remainder of her physical examination was normal.

Her laboratory tests on admission revealed a WBC of $22.1 \times$

103/ML with neutrophils 87%, a hemoglobin level of 10.5 g/dL, and platelets $380 \times 103/ML$. blood sugar (F)-85 mg/dl, blood urea-126 mg/dl, serum creatinine-2.1 mg/dl, S. Na+146 mmol/l, S K+-3.6 mmol/l, serum amylase- 406 IU/L (normal ref: 25–125) and serum lipase- 414 IU/L (normal ref: 8–70). Lipid profile and corrected calcium level was normal. X ray abdomen not suggestive of intestinal obstruction. Ultrasonography of abdomen revealed bulky pancreas, no gall bladder stone.

She was treated with intravenous fluids, iv antibiotics and antiemetics. Her leukocytosis was resolved and serum creatinine level normalised. Since serum amylase and lipase level was raised, a CT scan of her abdomen with intravenous contrast was done after normalisation of serum creatinine. The CT scan showed bulky pancreas with peripancreatic fluid collection (modified CT severity index – 8/10). Her symptoms continued to improve during her course of hospitalization.

Discussion

Acute pancreatitis is among the most common gastrointestinal conditions requiring acute hospitalization.^[5] Gallstones and/or biliary sludge are the most prevalent (approximately 40%–50%) cause of acute pancreatitis, alcohol (approximately 20%) is the second most frequent cause of acute pancreatitis, while less frequent causes of acute pancreatitis include medication, endoscopic retrograde cholangiopancreatography, hypercalcemia, hypertriglyceridemia, surgery, and trauma.^[6,7] However, approximately 20% remain idiopathic.^[8] AP without abdominal pain has been rarely described in the literature. We reported

a diabetic patient admitted in our institution with pleural effusion and diagnosed as a case of acute pancreatitis.^[9] But this patient is a 92 yrs old lady without any comorbidity presented with nausea, vomiting without pain abdomen and diagnosed as acute pancreatitis.

Conclusion

Patient of acute pancreatitis may present without pain abdomen. Increased awareness is needed. An abdominal CT scan is essential in establishing the diagnosis of AP in patients with atypical presentations.

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