Pancreatitis in Pregnancy - A Case Report

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Abstract: Acute or chronic pancreatitis during pregnancy is a rare event and can be associated with high maternal mortality and fetal loss. We report a case of a 24 years Primi gravida at 21 weeks & 28 weeks of gestation, who presented twice with severe pain confined to the upper abdomen and radiating to the back and vomiting. The patient was diagnosed with acute pancreatitis, which was managed conservatively.

Keywords: Pancreatitis, epigastric pain, serum lipase, conservative management

1. Introduction

Affects approximately 1 in 10,000 individuals & frequency of the disorder doesn’t change in pregnancy. 10% of pregnant women develop stones or sludge & 4% maintain them to postpartum period. Cholelithiasis is thought to be the most common causative factor of acute pancreatitis, but, in many cases, the cause remains unclear. Affects approximately 1 in 10,000 individuals and frequency of the disorder doesn’t change in pregnancy.

Inflammation triggered by factors that cause activation of pancreatic trypsinogen followed by autodigestion. Pathogenesis is by cell-membrane disruption, proteolysis (proteases), edema, haemorrhage (elastase) and fat Necrosis (lipases, phospholipases).

Causes are cholelithiasis (MC), hyperlipidemias, viral infections (HIV /EBV /Mumps /Coxsackie/CMV / Varicella / Hep A & C), hyperparathyroidism, congenital duct anomalies, ERCP, alcohol abuse, drug-induced, autoimmune, Non-biliary, trauma. Acute fatty liver of pregnancy and CFTCR gene mutations.

Symptoms & Signs are severe epigastric pain–radiating to back, ‘fetal position’ – flexed knees, hips & trunk, nausea, vomiting, fever, diffuse abdominal tenderness, tachycardia, bowel sounds hypoactive- due to ileus.

Investigations include – Biochemical - Leucocytosis, S.Amylase - >100 U/100 ml, S.Lipase - > 200 U/100 ml, Triglycerides - > 1000 mg/dl, LFT – elevated T:Bilirubin (>1.3), AST (>35) & LDH , Amylase-creatinine clearance ratio, S.Ca2⁺, S.K⁺ , S.Mg²⁺ - reduced, Blood Sugars elevated & CRP is elevated. Radiological - Ultrasound abdomen & MRCP.

Differential diagnosis to be ruled out are duodenal ulcer perforation, acute cholecystitis, acute hepatitis, small bowel obstruction, mesenteric ischemia, diabetic ketoacidosis and pre-eclampsia.

2. Case Report

A 24 yrs old Mrs.Sowmiya, primigravida of gestational age 21 weeks & 3 days had come to our OPD with complaints of severe epigastric pain for a day which was colicky, radiating to back , vomiting - 2 episodes that day, non projectile, contains food particles not bile or bloodstained. She was able to perceive fetal movements well. Patient gives history of similar complaints in the past few years but didn’t get it evaluated.

On examination:

a) GC – fair , afebrile
b) Not anaemic
c) Thyroid, breast – NAD
d) Vital signs – stable
e) CVS – S1, S2 heard, no added murrums.
f) RS – B/L NVBS heard, no added sounds.
g) P/A: Uterus corresponding to 20 weeks

- Fetal parts (+)
- Tenderness (+) over epigastric region
- No guarding / rigidity
- Bowel sounds heard

3. Investigations

<table>
<thead>
<tr>
<th>Investigations</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.Amylase</td>
<td>1220 IU/ml</td>
</tr>
<tr>
<td>S.Lipase</td>
<td>2220 IU/ml</td>
</tr>
<tr>
<td>WBCs</td>
<td>10130 cells</td>
</tr>
<tr>
<td>TGL</td>
<td>210 mgs/dl</td>
</tr>
<tr>
<td>Ca²⁺</td>
<td>7.1 mgs/dl</td>
</tr>
</tbody>
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USG shows main pancreatic duct dilatation of 5-6 cms & cholelithiasis.

4. Discussion

Treatment given was hydration with IV fluids, anti-emetics and antacids. Her biochemical values became normal and her symptoms also subsided eventually. She again came at 28 weeks with similar complaints and treated. Medical gastro-enterologist opinion obtained – to continue the same treatment. Both times she was managed conservatively & delivered a healthy baby.

5. Conclusion

Since acute pancreatitis can be fatal, early diagnosis will help in better maternal and fetal outcome. Therefore it is important to consider acute pancreatitis when a pregnant woman presents with upper abdominal pain, nausea and vomiting in order to improve fetal and maternal outcomes for patients with acute pancreatitis. Therefore, it is important to have multi-disciplinary approach involving the obstetrician, surgeon, gastroenterologist and radiologist.

References