CASE REPORT

Acute necrotising pancreatitis

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DIAGNOSES

Chronic pancreatitis with peri pancreatic cystic lesions and abscesses

CASE HISTORY

This 66 years old male patient had a history of 10 days of upper abdominal pain accompanied by nausea. Known chronic recurrent pancreatitis. Hospitalised for severe pains. Development of septic condition under adequate treatment. Development of peri pancreatic cystic lesions and abscesses

PHYSICAL INVESTIGATION

Blood pressure 130/80 mmHg, Heart frequency : 100 x/min, Cardiopulmonary with the standard range. Epigastric pain (+)

LABORATORY

Hb : 12,7; Leucocytes : 8,4; Thrombocytes : 384; Protein totally : 8,3; Albumin : 3,0; Bilirubin total : 0,75; Bilirubin direct : 0,44; Bilirubin indirect : 0,31; SGOT : 38; SGPT : 42; Gamma GT : 72; Alkaline phosphatase : 248; Amylase : 212; Lipase : 157

CT SCAN

Chronic pancreatitis with peri pancreatic abscess in the head, body and tail of the pancreas. Infiltration into the colonic mesentery. Abscess adjacent to the stomac and left colon. gaster.

Fig. 1: CT scan with cystic lesion in pancreatic tail, abscess formation peri pancreatic

Fig. 2: CT scan with enlarged body and tail of pancreas, cystic lesion with fluid and air inclusion
INDICATION

Patient develops a septic condition in ICU while being adequately treated for pancreatic cyst. The follow-up CT-scan demonstrates air in the cystic mass and enlargement of massive peripancreatic oedema. The clinical condition is deteriorating.

OPERATION

- necrosectomy
- peritoneal lavage
- continuous percutaneous peritoneal lavage

Fig. 3: Dissection of gastrocolic ligament. Opened bursa omentalis. Necrotic tissue on cavity of former pancreatic tail

Fig. 4: Removal of necrotic tissue out of pancreatic cavity

Fig. 5: Necrotic tissue removed

Fig. 6: Closed percutaneous abdominal lavage with two large tubes for evacuation on the right and tree small tubes for rinsing ion the left side
HISTOLOGY
Necrotic pancreatic tissue

POSTOPERATIVE DIAGNOSIS
Peri pancreatic necrosis

CLINICAL COURSE
Protracted stay on ICU with improving condition. Removal of lavage after one week. Cholecystectomy after full recovery. No further postoperative complications.

PROBLEMS
Treatment and operative procedures in necrotising pancreatitis are discussed controversially. The timing and indication for surgical intervention is crucial for successful treatment. An indication for surgery is only given if the necrosis is proven to be infected. Adequate surgical treatment encompasses removal of the necrosis and an additional procedure like open packing, planed second looks or the addition of the peritoneal lavage.