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ORIGINAL RESEARCH PAPER

Surgery

PANCREATIC ABSCESS: A RIDDLE OF PANCREATOMA

KEY WORDS: Pancreatic abscess, Chronic pancreatitis, PTBD(Percutaneous Transhepatic Biliary Drainage),

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ABSTRACT

This is a case of a 35 year old male presenting with Obstructive jaundice due to a Pancreatic head mass.

INTRODUCTION

A pancreatic abscess is defined as a circumscribed intra-abdominal collection of pus that is typically in the vicinity of the pancreas and contains little pancreatic necrosis.

occur via colonic translocation of bacteria.

develops in patients with pancreatic pseudocyst that become infected

Infection of the pancreas occurs in 5–9% of patients with acute pancreatitis [1].

complication in patients undergoing early operation for management of haemorrhagic or necrotizing pancreatitis

Other causes include penetrating duodenal ulcer, infection of an established pseudo cyst, pancreas divisum, and penetrating pancreatic trauma.

gram-negative flora bacteria, especially *Escherichia coli*, *Klebsiella*, and *Pseudomonas*[2]

Case Description

Patient particulars:-

35 year old non alcoholic diabetic male patient

Chief complaint:-

H/O Jaundice for last 3 months with mild epigastric pain and dyspepsia following meals. Fever with chills and rigor and increased intensity of epigastric pain for 7 days

MDCTW/A:-

Chronic Calcific pancreatitis with grossly bulky head and uncinated process and an ill defined heterogenous area in uncinated process- sequeale of focal acute inflammatory changes/ ? neoplastic changes

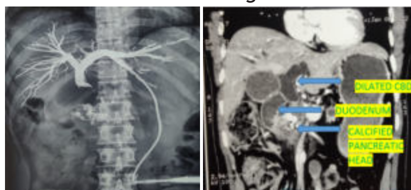
CT guided FNAC from head mass:– Chronic pancreatitis

SVE:- CCP with distal CBD stricture and duodenal narrowing

CA 19-9:- 239.89

Provisional Diagnosis:-

Chronic calcific pancreatitis with Obstructive jaundice due to Pancreatic Head Mass with Cholangitis



Management-

Conservatively→ERCP with biliary and pancreatic stenting attempted but failed→PTBD done→Patients general condition improved

Roux en y Lateral Pancreatico jejunostomy with Gastrojejunostomy and Choledochoduodenostomy done

Intraoperatively:-

Large Pancreatic head mass noted with PANCREATIC ABSCESS formation over anterior surface.

Frozen section biopsy:- Fibro fatty tissue with chronic inflammatory cell infiltration. Roux limb could not be mobilised upto CHD hence Choledochoduodenostomy done

Postoperatively- Patient recovered well, PTBD clamped and removed

DISCUSSION

Pancreatic abscess is a late complication of acute necrotizing pancreatitis, occurring more than 4 weeks after the initial attack. A pancreatic abscess is a collection of pus resulting from tissue necrosis, liquefaction, and infection. It is estimated that approximately 3% of the patients suffering from acute pancreatitis will develop an abscess.

In radiological imaging, an enlargement that is focal or diffuse, mild peripancreatic inflammations or a single collection of fluid (pseudocyst) have less than 2% chances of developing an abscess [3]. However, the probability of developing an abscess increases to nearly 60% in patients with more than two pseudocysts and gas within the pancreas.[4]

Histology review of patients diagnosed with pancreatic abscesses revealed that 65% were due to chronic pancreatitis, 22% from biliary tract disease, 5% were from duodenal diseases, and the remainder was from other causes.[5]

Abdominal computed tomography (CT) scan with contrast and contrast-enhanced magnetic resonance imaging (MRI) are both options for assessment of pancreatic necrosis and abscesses, although CT is more commonly used. On imaging, the presence of extraluminal gas in the pancreatic and/or peripancreatic tissues is consistent with an underlying infection.[6]

The prognosis depends on the severity of the infection. It is a potentially severe complication that may result in the death of the patient if the appropriate management is not given. Patients are at risk of multiple organ failure and sepsis, and in cases in which the infected abscess is not removed either

surgically or endoscopically, the mortality rate can reach 100%.

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