Original Article

The Journal of the Association of Physicians of Tamil Nadu,
Vol. 2, Issue 2, English Quarterly, April – June 2023

A Case of Necrotising Pancreatitis in a Non-Alcoholic with Splenic Artery Bleeding

Prof. Dr. TV Devarajan, Dr. Marcella Sherin, Dr. Kevin Danie Raja A, Dr. Suryavanshi Pallavi Bhimrao, Dr. Ekansh Pillay, Miss. Kamaleswari.S

Apollo First Med Hospital, Kilpauk, Chennai.

Introduction:

Necrotizing pancreatitis is a severe and potentially life-threatening inflammation of the pancreas, often associated with alcohol abuse and gallstone disease. However, it can manifest in atypical patient populations and present with unique complications that challenge even the most seasoned healthcare professionals. In this case report, we present a compelling instance of necrotizing pancreatitis in a non-alcoholic individual, further complicated by splenic artery bleeding—an uncommon and potentially lethal complication.

A 32-year-old male presented with fever, abdominal pain, and vomiting. Ct- abdomen revealed features of necrotizing pancreatitis. He had shock and altered consciousness due to ketoacidosis. After Pancreatectomy he developed bleeding from the splenic artery which was embolized and the patient became stable and discharged.

Figure: 1 Patient in intensive care
IV antibiotics and insulin infusion

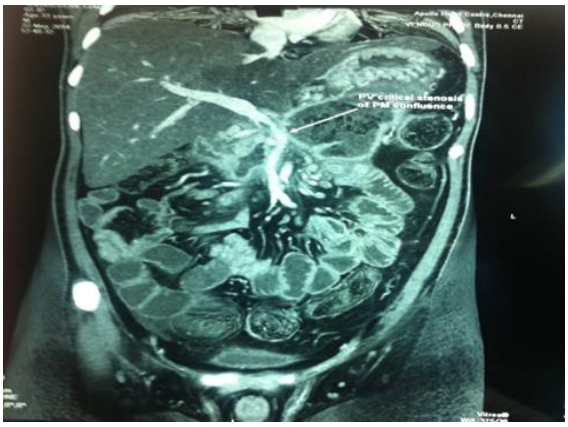

Figure: 2 CT – Abdomen

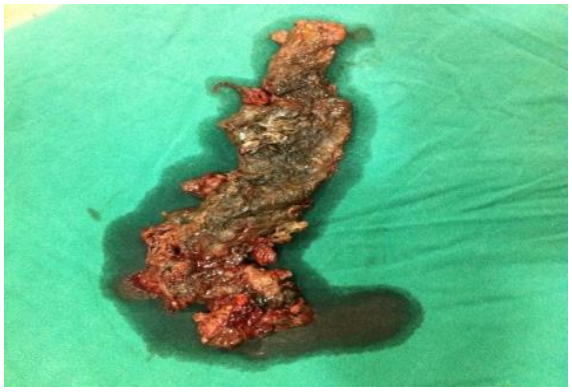

Figure: 3 Resected Pancreas

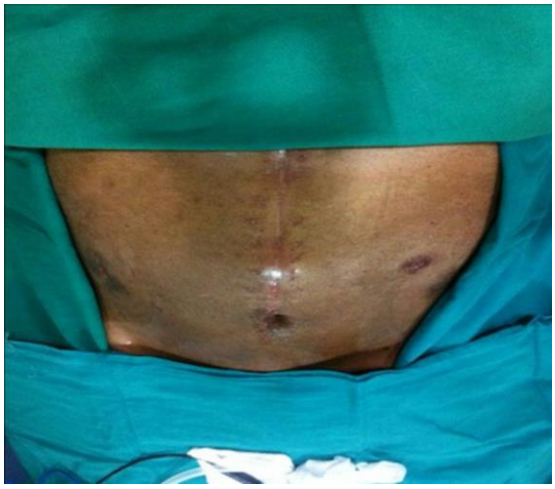

Figure: 4 Post Operative

The period abdomen was distended due to blood in the peritoneal cavity because of splenic artery bleeding.

Figure: 5 Drained Fluid- Blood

Figure: 6 At the Time of Discharge

Role of our clinic

This patient came to the hospital in a state of shock due to septic necrotizing pancreatitis with ketoacidosis. He was given round-the-clock insulin and IV antibiotics but did not show improvement, hence laparotomy was done, and the pancreas was found to be fully necrosed and filled with pus. He underwent total pancreatectomy and blood sugar was controlled with IV insulin.

Under observation, he developed abdominal distension and peritoneal tapping revealed frank blood. CT revealed an opened-up splenic artery with torrential bleeding following which he was taken to the main hospital and was seen by an interventional radiologist who embolized the splenic artery, after which the bleeding stopped.

The role of an advanced care clinic in this case of very serious sepsis requiring major surgery and embolization of the splenic artery were modern methods of preventing bleeding and sepsis.

We had a good 320-slice CT abdomen for diagnosis. Total pancreatic resection was done. Good post-operative care was given, and embolization of the splenic artery was done, because of bleeding from the opened-up splenic artery. In general, necrotizing pancreatitis has a high mortality rate.

In conclusion, we present this case as a testament to the need for vigilance and thorough evaluation when encountering pancreatitis cases in individuals without conventional risk factors. The intricate nature of this case illustrates the importance of tailored approaches to diagnosis and management, with the ultimate goal of achieving favorable outcomes for patients facing this complex clinical scenario.