

Acute gallstone Pancreatitis in Pregnancy: A Case Study in GUH

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Introduction

Acute pancreatitis (AP) during pregnancy is a rare disease with an estimated incidence rate of about 1 case per 1000 to 10 000 pregnancies and can be associated with high maternal mortality and fetal loss especially in case of improper management or late diagnosis. Gallstone disease is the most common causative factor of acute pancreatitis, but, in many cases, the cause remains unclear.

Modified Glasgow Scoring for risk of severe pancreatitis in the nonpregnant patient
Score 1 point for each parameter present. A score of 3 or more puts the patient at risk of severe pancreatitis

P- Arterial oxygen saturation (PaO₂) <8 kPa

A- Age >55 years

N- Neutrophils white cell count >15x10⁹/L

C- Calcium <2.0 mmol/L

R- Raised urea >16 mmol/L

E- Enzymes: lactate dehydrogenase >600micro/l

A- Albumin <32 g/L

S- Sugar glucose >10 mmol/L

Case Report

We report a case of a 27 years old primip who presented at 23+3 weeks gestation, with severe acute onset of right upper quadrant (RUQ) abdomen pain and radiating to the back, loss of appetite, ongoing vomiting in pregnancy. Previously had an abdominal ultrasound a month to presentation which showed gallstones. On examination, there was tenderness in epigastrium and RUQ, Murphy’s sign positive associated with elevated serum amylase 7129, Liver function test (LFT) alanine transaminase 257, and aspartate transaminase 271, gamma-glutamyl transferase 71.

Conservative management with Intravenous fluids, antibiotics, analgesia and antiemetics were started and there was improvement by the following day clinically and biochemical reports as serum amylase dropped to 1577 and 194 by day3 with improved LFT’s blood results. The patient did not experience any complications, currently in her late 3rd trimester.

Recommendation

This case emphasizes the importance of early diagnostic studies and proper therapeutic management to help reduce maternal/fetal mortality associated with acute pancreatitis during pregnancy. Treatment of AP in pregnancy should be carried by a multidisciplinary team and could be either conservative management or surgical intervention according to the severity of presentation, the general maternal and fetal condition.