

Recurrent acute pancreatitis in pregnancy in a patient who has undergone cholecystectomy: A treatment paradigm based on our hospital experience.

Jatheeswaran K1, Pinnaduwa S1, Karunanayake V1, Marleen S1
1 Sri Jayewardenepura General Hospital

Introduction

Acute pancreatitis in pregnancy is a rare event affecting around 3:10,000 pregnancies. The common predisposing causes of pancreatitis in pregnancy are cholelithiasis and hypertriglyceridemia²

Case

A 30-year-old woman in her second pregnancy presented at 35 weeks gestation with acute onset epigastric pain of one-day duration. During her first pregnancy, she was diagnosed with acute pancreatitis in the third trimester and underwent a category two caesarean section at 39 weeks gestation. It resulted in a neonatal death at 14 days due to meconium aspiration syndrome. One year later, she underwent a laparoscopic cholecystectomy. On admission, her pancreatic amylase was elevated (495U/L) and ultrasound scan showed features of pancreatitis. Other biochemical investigations including complete blood count, coagulation profile, liver profile and renal profile were normal. Following the diagnosis of acute pancreatitis, she was managed by a multidisciplinary team with a low-fat diet, intravenous (IV) cefuroxime, IV metronidazole, IV ranitidine, and IV pantoprazole.

Due to persistent epigastric pain, a category four caesarean section was performed at 35 weeks and four days gestation, following which the patient's symptoms resolved. The baby was discharged home after seven days stay in NICU.

Discussion

Diagnostic blood tests for acute pancreatitis include serum amylase and lipase, with serum lipase being more sensitive. Imaging of the pancreas can be performed using an abdominal ultrasound scan, CT scan and MRCP (superior for biliary aetiology).³

Conservative medical management is the mainstay of treatment with analgesics, intravenous fluid therapy, probiotics, a fat-free diet and antibiotics.³ Ideally, laparoscopic cholecystectomy and ERCP should be performed in the second trimester for those not responding to medical treatment. During the third trimester, delivery should be expedited for those not responding to conservative management, following which cholecystectomy should be considered. Among women who have undergone a cholecystectomy, as in our case, non-biliary causes like hyperthyroidism, hereditary causes, acute fatty liver in pregnancy, and preeclampsia should be excluded.

Conclusion

Acute pancreatitis in pregnancy could be due to biliary or non-biliary causes. It has a high recurrence rate in subsequent pregnancies. Early diagnosis and management is vital in preventing adverse maternal and fetal outcomes. Conservative management is the mainstay in treatment. Advances in imaging and therapeutic endoscopy have contributed to improvements in pregnancy outcomes.

References

1. Priyanka Rajandran, Papa Dasari and Chitra Thyagarajan Recurrent acute pancreatitis In pregnancy International Journal of Clinical Obstetrics and Gynaecology 2021; 5(5): 139-142
2. . Hot S, Eğin S, Gökçek B, Yeşiltaş M, Karakaş DÖ. Acute biliary pancreatitis during pregnancy and in the postdelivery period. Ulus Travma Ve Acil Cerrahi Derg Turk J Trauma Emerg Surg TJTES 2019;25(3):253-8.
3. Abdullah B, Kathiresan Pillai T, Cheen LH, Ryan RJ. Severe Acute Pancreatitis in Pregnancy. Case Rep Obstet Gynecol 2015;2015:e239068.