Acute Pancreatitis

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Acute pancreatitis is rare in childhood, more so in children below ten years of age. The common causes of pancreatitis include structural malformations of biliary and pancreatic duct system, trauma, vascular diseases, endocrine and metabolic diseases, drugs and infections. Diagnosis of acute pancreatitis in septicemia or bacterial infections is usually postmortem(1). We report a case of acute pancreatitis in a girl who presented initially with dysentery.

Case Report

A 2½-year-old girl was admitted with a history of loose stools with blood and mucus for eight days, moderate degree of continuous fever and occasional vomiting for two days. For these, she received some treatment from a general practitioner subsequent to which the loose stools were better but she developed abdominal distention. Physical examination revealed a febrile and toxic looking child with a heart rate of 110 per minute, respiratory rate of 32 per minute and blood pressure of 108/60 mm of Hg. There was generalized abdominal distension with infrequent peristaltic sounds. A diagnosis of acute gastroenteritis with drug induced paralytic ileus was made and conservative treatment was started which included intravenous fluids, ampicillin (100 mg/kg/day), gentamicin (5 mg/kg/day) and continuous gastric aspiration.

Investigations revealed a hemoglobin of 10.5 g/dl, total leucocyte count of 22,000 with 80% polymorphs and a sedimentation rate of 10 mm in first hour. Her liver function tests, renal function tests and serum electrolytes were within normal limits. Serum calcium value was 8 mg/dl and phosphate was 4.0 mg/dl. *X*-ray film of abdomen showed gaseous distension with air fluid levels suggestive of paralytic ileus. Serum widal done on day seven of admission was positive in titres of 1 : 240 for both 'O' and 'H' antigens. Her blood culture and stool culture grew no organisms. Since the abdominal distension persisted for four days, ultrasonography of abdomen was done which showed marked enlargement of pancreas mainly in its body and tail with hypodense areas suggestive of edema and inflammatory process. There were no structural anomalies in other organs, including common bile duct. Serum amylase taken on day five, after ultrasonography report was 240 IU/L (normal 5-65 IU/L). Her abdominal distension decreased gradually and oral feeds were started after sixth day, but fever responded after eight days of treatment. Antibiotics were continued for fourteen days. Repeat ultrasound scan on day fifteen revealed decrease in pancreatic edema but with evidence of pseudocyst formation. She did not come for follow up.

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Discussion

Acute pancreatitis was diagnosed mainly by demonstrating increased levels of serum amylase and lipase in the past, but now ultrasonography is a helpful tool in diagnosis(2). In acute stage of pancreatitis, levels of serum amylase are increased.to as high as three fold above normal but these come down to normal levels within 48-72 h; however, high values may persist if there is pseudocyst formation(1). In our case pseudocyst formation could have caused persistent rise in serum amylase level.

In our patient we could not identify a cause for acute pancreatitis from the list of common causes(1). Our patient presented with acute dysentery and her widal test was positive indicating a possible involvement of salmonella species in the disease process. Recently, a high incidence of pancreatitis with acute gastroenteritis secondary to salmonella infection has been reported in adults(3). No organisms could be isolated in our patient from stool and blood probably because of prior antibacterial treatment.

REFERENCES

1. Soergel KHH. Acute Pancreatitis: Etiology and Pathogenesis. *In:* Berk's Gastroenterology, 4th edn. Ed Berk JE. Philadelphia, WB Saunders and Company, 1985, pp 3971-3992.

2. Taylor KJW, Buchin PJ, Viscomi GN, *et al*. Ultrasonographic scanning of pancreas: Prospective study of clinical results. Radiology 1981, 138: 211-213.

3. Fielddrish R, Christian N, Bauernikolaus D. High frequency .concomitant pancreatitis in salmonella enteritis. Lancet 1991, 337: 1611.

Intrauterine Intussusception as a Cause of Intestinal Atresia

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Intrauterine intussusception is a very rare cause of intestinal atresia. The pathogenesis of this disorder is still unknown. We report an ileal atresia due to intrauterine intussusception in which the intussusceptum was seen inside the post-atretic blind intestinal segment.

Case Report

A 2-year-old, full-term male baby weighing 2.6 kg was admitted on 9.4.90 with a history of bilious vomiting and abdominal distension since the age of 15 hours. No meconium had been passed after birth. The mother had polyhydramnios during pregnancy. Examination of the baby revealed abdominal distension and moderate dehydration. An erect roentgenogram of the abdomen showed multiple air-fluid levels with no gas shadows in the true pelvis, suggesting a small bowel obstruction.

The baby was hydrated with intra-

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