# Case Report

# A Case of Acute Pancreatitis

**Urgent message:** Although pancreatitis is a common cause of abdominal pain, many of its signs and symptoms are shared by other intra-abdominal conditions. Most patients can be handled on an outpatient basis if diagnosis is accurate, as this case illustrates.

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## Introduction

Abdominal pain is a common and varied presentation in urgent care. A history and physical exam can be used to triage the majority of emergent cases. Strong communication is vital to ensuring good outcomes and minimizing misses.

## Case Presentation

C.O. is a 35-year-old white male presenting with new-onset mild epigastric pain for one day. The pain was episodic at first but became constant. It was localized to the epigastrium, achy, dull, not related to activity, non-radiating, and rated 4/10 at presentation. The pain worsened with movement and was relieved by sitting. No fever, nausea, vomiting or change in bowel movements were reported.

## Observations/Findings

Evaluation of the patient revealed the following:
PMHX: GERD, hypertriglyceridemia
MEDS: Fenofibrate (Tricor), TUMS
Allergies: None
PSHX: None
Social: No tobacco, drugs, or alcohol
FH: Non-contributory
ROS: Cough on and off for one week, nonproductive, without dyspnea or wheezing.

PE:

- Temp: 99.1° F
- P: 72
- R: 18
- BP: 125/85
- $O_2$ sat 97% RA
- Well-appearing male in no apparent pain.
- Skin/MSI: No rashes or joint deformities or ecchymoses
- COR: RRR, no M/R/G
- RESP: CTAB, no W/R/R
- ABD: +BS, soft, mild localized pain on palpation in epigastrium. No rebound or guarding. All other quadrants were benign

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Diagnostics:

- ECG: Normal

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- Troponin: 0.0
- U/A: Normal
- CMP: LFTs were a send-out. BMP normal, except Glu113
- Amylase/lipase: Send-out
- CBC: Normal
- CXR: Normal

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### Laboratory Results

Since a few lab results were pending and the patient was in no acute distress, a decision was made to hold off on the CT scan until the labs arrived. Of note, a GI cocktail did not alleviate the pain. The patient was sent home with expectant management.

Later that day, the labs arrived:

- Serum bilirubin: 0.7
- Amylase: Normal
- Lipase: 426H (NL 114-286)
- LFTS: Unable to complete due to "milky" serum!

Patient was contacted and asked to fast that evening and return in the morning for a fasting lipid panel and an ultrasound. The results:

- Triglycerides:1653
- Cholesterol: 222
- Abdominal U/S: Liver hepatosteatosis, pancreas normal, no gallstones

### Diagnosis

Acute pancreatitis. Cause: hypertriglyceridemia.

### Course and Treatment

Interestingly, patient had stopped taking Tricor a few weeks earlier. His primary care physician was contacted. He confirmed the patient's triglycerides were in the normal range two months earlier. A follow-up appointment was made for the patient with his primary doctor for LFTs +/- CT scan on outpatient basis. A follow-up call two days later revealed cessation of abdominal pain.

### Discussion

Pancreatitis is a common cause of abdominal pain. Its clinical presentation can vary from mild abdominal pain to refractory shock. Many of its signs and symptoms are shared by other intra-abdominal conditions. The two most common causes are gallstones and alcohol, which account for nearly 90% of cases. Drugs account for up to 50% of the remaining cases. Metabolic disturbances (triglycerides), infection, inflammation, and trauma account for the rest.

The major symptom is mid-epigastric or left upper quadrant pain, mostly constant, boring pain that often radiates to back, flanks, chest, or lower abdomen. The pain is exacerbated in the supine position and can be relieved with sitting. Nausea, vomiting, and bloating are common. A physical exam may reveal low-grade fever, tachycardia, diminished bowel sounds (ileus), epigastric tenderness, and peritonitis (late finding). Cullen's sign (bluish discoloration around the umbilicus) and Grey Turner's sign (bluish discoloration of the flanks) are rare but characteristic signs of hemorrhagic pancreatitis.

Serum amylase and lipase are the most widely used tests in evaluating pancreatitis. Lipase is a more accurate test than amylase (90% sensitivity and specificity).

Plain radiographs are most useful in excluding other diseases, such as perforation or obstruction. Ultrasonography is most helpful in gallstone identification or biliary dilatation. Pancreatic edema and pseudocysts can also be identified. A CT scan is the most important imaging test for the diagnosis of acute pancreatitis and its intra-abdominal complications, as well as for assessment of severity. Patients with clinical and biochemical features of pancreatitis who do not improve with initial conservative therapy or those suspected of complications should undergo a CT scan of the abdomen.

Ninety percent of patients require supportive measures only. The general principle is: "Rest the pancreas." Fluids, pain medication, and anti-emetics are examples of these supportive measures. Empiric antibiotics are not indicated in mild to moderate disease. Patients with mild disease and no evidence of systemic complications can be managed on an outpatient basis, if tolerating meds PO and pain is well-controlled. A clear liquid diet is recommended and a follow-up in 24-48 hours is needed. All other patients should be admitted to the hospital. Complications include pseudocyst, abscess, hemorrhage, hypocalcemia, hyperglycemia, and acute respiratory stress syndrome (ARDS).

### Conclusion

A careful history, judicious diagnostics, strong communication, and close follow-up allow for effective evaluation and management of most cases of acute abdominal pain in the urgent care setting. Pancreatitis is a fairly common cause of such pain and can be managed in the majority of cases on an outpatient basis. ■