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A Case Report On Obstructive Jaundice With Periampullary Adenocarcinoma And Cholangitis

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ABSTRACT:
Introduction: Obstructive jaundice is one of the most typical clinical signs caused by inflammation, gallstones or tumours of the periampullary region. Painless and progressive rise of serum bilirubin, is mostly attributed to tumorigenic entities, rather than inflammatory process.
Case presentation: A 48 -year-old- male admitted in Tertiary care hospital Wardha,at surgery ward. With the complaints of pain in the right upper abdomen, yellowish discolouration of urine, fever since 1month and nausea, vomiting since 15 days and loss of appetite . his relatives went to the hospital for further treatment. No history of hematemesis, loss of consciousness. No history of trauma. Previous treatment, no prior hospitalization. There was no associated illness were present like Diabetes mellitus, tuberculosis, and thyroid disorder. No any significant past history. Physical examination and systemic examination was done. In respiratory system: bilateral clear, cardiovascular: heart sound was normal, central nervous system: conscious and oriented, abdominal examination: upper abdomen tenderness present. no lymphadenopathy, pupil examination showed equal and pale conjunctiva, sclera looked jaundice.Bowel sound were present. No any abnormality detected in musculoskeletal system.
Therapeutic management: Patient was admitted to surgery ward for conservative management. All the routine investigation done. Total bilirubin of 3.0 mg/dl , direct bilirubin, 2.5 mg/dl . The patient had been investigations for example, blood test, kidney &liver function test,Physical examination, X-ray, Imaging test such as CT scan, MRI, ultrasonography, endoscopy should be performed.(ERCP)endoscopic retrograde cholangiopancreatography and stenting this procedure surgeon will performed before surgery. ECG which was normal. Patient was started on antibiotics, analgesic, antacid, analgesic, vit K, and another supportive medication. surgery opinion was taken SOS in emergency. Surgery opinion was taken and patient was advised for conservative management. **Conclusion:** due to conservative management and quality nursing care patient condition was stable and had no active complaints at present hence patient is being discharged.

Keywords: Obstructive Jaundice, Periampullary Adenocarcinoma

INTRODUCTION:

Obstructive Jaundice is a common problem that occurs when there is an obstruction to the passage of conjugated bile from liver cells to intestine. Endoscopic retrograde cholangiopancreatography (ERCP) has become the one of treatment modality for patients with obstructive jaundice because of its therapeutic capabilities.[1]
The success rate of ERCP for treatment is highly variable ranging from 50% to 96% depending on the operator, endoscopic aspect, disease severity, and anatomical abnormality. Jaundice due to biliary obstruction may be caused by a heterogeneous group of diseases that include both benign and malignant conditions.[2]
The majority of patients with periampullary cancers will present with biliary obstruction due to the location of the tumor. Often, this obstruction will lead to symptoms such as jaundice, abdominal discomfort, pruritus, and nausea. Many patients will require endoscopic or surgical decompression of the biliary tract to relieve obstruction, mitigate symptoms, and improve quality of life. The only potentially curative treatment for ampullary carcinoma is surgical resection. Complete tumor resection with negative margins is a prerequisite for cure.
A primary ampullary carcinoma from other periampullary tumors preoperatively. However, true ampullary cancers have a better prognosis than periampullary malignancies of pancreatic or bile duct origin. Respectability rates are higher, and five-year survival rates are approximately 30 to 50 percent in patients with limited lymph

node involvement. By contrast, less than 10 percent of patients with completely resected node-positive pancreatic cancer are alive at two years. Thus, an aggressive approach to diagnosis and treatment of periampullary tumors is needed to ensure that patients with these comparatively favorable cancers are treated optimally.[3]

The majority of patients with malignant tumours may not be suitable for surgery, hence, chemotherapy and/or radiotherapy will be the next best option. For such patients, obstructive jaundice can be relieved by inserting a stent by endoscopic guidance or radiologic guidance, once the diagnosis of cancer is established.

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Case History:

A surgical case was taken by Tertiary Care Hospital Wardha, Maharashtra, India. This complicated case was taken care of nicely by the hospital because of expert medical team management and excellent nursing care.

Patient information:

We report a 48 -year-old- male admitted in Tertiary care hospital Wardha,at surgery ward. With the complaints of pain in the right upper abdomen, yellowish discolouration of urine, fever since 1month and nausea, vomiting since 15 days and loss of appetite. his relatives went to the hospital for further treatment. No history of hematemesis, loss of consciousness. No history of trauma. Previous treatment, no prior hospitalization. There was no associated illness were present like Diabetes mellitus, tuberculosis, and thyroid disorder. No any significant past history. Physical examination and systemic examination was done. In respiratory system: bilateral clear, cardiovascular: heart sound was normal, central nervous system: conscious and oriented, abdominal examination: upper abdomen tenderness present. no lymphadenopathy, pupil examination showed equal and pale conjunctiva, sclera looked jaundice. Bowel sound were present. No any abnormality detected in musculoskeletal system.

Physical examination was done:. Height is 172cm, and weight is 60kg. Temperature is 99 F, Pulse: 80 beats per min, respiration is 24 breaths per minute ,Blood pressure: 120/70 mm Hg,

Medical Family and Psycho-Social History:-There were no history of comorbidities in patient's family. Patient belongs to middle class family. He is living with his wife and 2 son. Patient maintain good interpersonal relation with family members, relatives and neighbours. Patient do not have bad habit like smoking, tobacco chewing and alcoholism.

Relevant past intervention with outcomes: - For above mentioned complaints patient was admitted in private hospital. He was get relief from that hospital. That's why patient referred to tertiary care hospital Wardha.

Diagnostic Assessment:

All the routine investigations were done: Total bilirubin of 3.0 mg/dl, direct bilirubin, 2.5 mg/dl. Red blood cells: 3.23, White blood cells: 8500, MCHC: 31.4, MCV: 64.4, MCH: 20.2, Total platelet count: 3.43, HCT: 17.6, ALT :45u/l , AST: 39u/l .Kidney function and liver function test were done. ECG and X-ray was done which was normal. Infection is detected through a physical examination of the affected body part and blood testing. Drain samples or tissue cultures are identify the microorganisms that caused the condition. After the endoscopy and scans can be performed.

Therapeutic management: Patient was admitted to surgery ward for conservative management. All the routine investigation done. Total bilirubin of 3.0 mg/dl , direct bilirubin, 2.5 mg/dl . The patient had been investigations for example, blood test, kidney &liver function test, Physical examination, X-ray, Imaging test such as CT scan, MRI, ultrasonography, endoscopy should be performed. (ERCP)endoscopic retrograde cholangiopancreatography and stenting this procedure surgeon will perform before surgery. ECG which was normal. Patient was started on antibiotics, analgesic, antacid, analgesic, vit K, and another supportive medication. surgery opinion was taken SOS in emergency. Surgery opinion was taken and patient was advised for conservative management.

Treatment on admission:IV fluid administered,Inj Piptaz 4.5gm TDS , Inj Omeprazole 40mg OD, Inj emset 4mg BD, and vitamin k 10mg OD , Inj. Paracetamol 1g IV BD, Inj standard 100ml SOS.

Treatment on Discharge: Inj Cefazolin 1gm IV BD, Tab . paracetamol 500mg SOS, Inj . Gentamycin 160 mg IV , Tab pan 40 mg BD.

Patient was stable and had no active complaints at present. Hence patient is being discharged.

Prognosis: - After getting treatment prognosis was satisfactory.

Follow-up and outcomes: Despite the most significant efforts of the Patient, their vibrant health will improve, and her health status will improve even more. Follow-up in case of following signs and symptoms patient are requested to attend the emergency department. Diagnostic and other test findings are critical.

Discussion:

A 48 -year-old- male admitted in Tertiary care hospital Wardha,at surgery ward. With the complaints of pain in the right upper abdomen, yellowish discolouration of urine, fever since 1month and nausea, vomiting since 15 days and loss of appetite . his relatives went to the hospital for further treatment. No history of hematemesis,

loss of consciousness. No history of trauma. Previous treatment, no prior hospitalization. There was no associated illness were present like Diabetes mellitus, tuberculosis, and thyroid disorder. No any significant past history.[4-6]

In obstructive jaundice, the patient's stools are pale (clay-coloured if obstruction is complete), bilirubin in urine with little or no urobilinogen and skin itches. Besides, patient has high blood levels of conjugated (posthepatic) bilirubin and his alkaline phosphatase is very high. These features are most marked in complete obstruction, as when carcinoma blocks the common duct.[7-10]

Study showed surgery in patients with obstructive jaundice caused by a periampullary (pancreas, papilla, distal bile duct) tumour is associated with a higher risk of postoperative complications than in non-jaundiced patients.6 Preoperative biliary drainage (PBD) was introduced in an attempt to improve the general condition and thus reduce postoperative morbidity and mortality. Gangliocytic paragangliomas are exceedingly rare tumors that arise in close proximity to the papilla of Vater and 90% are found in the second part of the duodenum.[11-13]

Obstructive jaundice is not common. In our case, jaundice was presumed secondary to mechanical obstruction of the ampullary orifice by the tumor. Immunohistochemistry is positive for cytokeratin, synaptophysin, neuron specific antigen and S-100 protein[2]. Endoscopic ultrasonography is useful for preoperative differential diagnosis such as gastrointestinal stromal tumors, carcinoids and periampullary adenoma.[14]

Conclusion:

A 48-year-old- male came in hospital with above mentioned complaints, in critical condition. On admission patient's complaints that he was pain in the right upper abdomen, yellowish discolouration of urine, fever since 1month and nausea, vomiting since 15 days and loss of appetite. On specific investigation patient diagnosedObstructive Jaundice With Periampullary Adenocarcinoma With CholangitisConservative treatment was given. After the treatment patient's prognosis was good. Overall Patient had given a positive response to treatment and patient was stable. Hence patient is being discharged.

Ethical approval: Not applicable

Patient Inform consent: While preparing a case report and for publication patient's informed consent has been taken.

Conflict of Interest :The Author declares that there are no conflicts of interest.

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