

Case Report on Acute Pancreatitis during Pregnancy

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ABSTRACT:

Introduction: Acute Pancreatitis in pregnancy is a rare occurrence with a high risk of maternal death and fetal loss. Gallstones are assumed to be the only prevalent cause of acute Pancreatitis; always this is not happen in the case. The actual etiology is unknown.

Patient History: A 26-year-old woman was admitted to a rural hospital's medical ward. With complaints of nausea, vomiting, and stomach pain spreading to the back, mainly in the upper right abdomen, urine is a dark tint. **Clinical findings:** The bloodtest increased liver enzymes, physical examinations, ultrasounds, and endoscopic ultrasounds indicated a dilated common bile duct and multiple gallbladder stones with average wall thickness were all performed on the patient.

Therapeutic interventions: The patient received minimal oral and intravenous fluids as part of a conservative treatment plan, analgesics, and normal saline, which is prescribed by doctor.

Outcome: The patient was given medication as prescribed by the doctor, such as analgesics. In addition, to medical treatment, the patient's condition improved.

Nursing perspective: Fluid replenishment with DNS and N.S. was given. Hourly check vital signs and blood pressure. Maintained the patient's intake and output and ensured she received enough rest and sleep.

Conclusion: Treatment and care for Pancreatitis during pregnancy on time will help prevent further complications.

Keywords: Acute pancreatitis; Gallbladder stones; Pregnancy

Introduction:

Although acute Pancreatitis during pregnancy is a rare occurrence, it is thought to impact 1 in 1000 to 1 in 10,000 women.^{1, 2} Confounded or slow-down treatment in such cases could have disastrous results, with a high mortality rate. The most common etiologies include biliary illness, congenital or acquired hypertriglyceridemia, and the presence of biliary disease. Acute Pancreatitis has been linked to low platelet count, pre-eclampsia, eclampsia, hemolysis, elevated transaminases, and H.E.L.L.P. syndrome on rare occasions.^{3, 4} Growing gestational age raises the risk of acute Pancreatitis. Increased cholesterol release in the hepatic bile, as opposed to phospholipids and bile acids, is thought to cause of Pancreatitis in pregnancy, especially in the second and third trimesters, resulting in more saturated bile. Furthermore, higher bile concentration is caused by more significant gallbladder volumes during fasting and postprandial times and reduced emptying volume. Finally, the enormous amount of concerted bile lingering in the sluggish gallbladder may contribute to forming gallstones and crystals.¹

There is no discernible difference of acute Pancreatitis clinical signs and symptoms between pregnant and non-pregnant women. Anorexia, nausea, vomiting, stomach pain, dyspepsia, and an aversion to fatty foods are a few symptoms. A low-grade temperature and tachycardia are the most common symptoms.⁴

Pancreatitis in pregnancy is due to Biliary aetiology (gallstones or sludge), but additional causes include hyperlipidemia or alcohol addiction. It is difficult to detect and treat since it has a fast onset of symptoms, numerous complications, and a high fatality rate. As a result, this sickness is frequently misdiagnosed, and treatment is commonly postponed, putting both mothers and newborns' health at risk. Following preterm delivery, acute

Pancreatitis was linked to a 50% high risk of death during delivery. A case of acute arising Pancreatitis in late pregnancy is described, as well as the aetiology and diagnosis. By way of example, we have an instance of moderate Pancreatitis complicating a third-trimester pregnancy that was carefully managed till a straightforward birth.

Patient information:

A female patient has been admitted to the rural hospital with complaints of nausea, vomiting, dark colour urine from last two weeks and abdominal discomfort at the upper right abdomen and it migrated to backside.

Primary concern & symptoms of the patient:

Nausea, vomiting, and stomach discomfort strike a 26-year-old woman in the upper right abdomen, spreading to the back. In the last two weeks, urine is dark in colour and her sleeping pattern has changed.

Family & psychosocial history: The patient is not active; she has a dual nature; hygiene and personal grooming are not maintained. Although the patient's mental state is normal and she is aware of time, place, people, and objects within her reach, the hospitalization and diagnostic process have caused slight behavioral alterations.

Clinical Finding:

Body build: thin (unhealthy)
Height: 156 cm
Weight: 50 kg
Temperature: 99°F
Pulse: 74 beat per minute
Blood pressure 110 /70 mmHg
Respiration: 24 breaths per minute
Abdominal examination: epigastric pain present

Diagnostic evaluation:

Ultrasound indicated a dilated common bile duct and multiple gallbladder stones with average wall thickness. It also revealed a single fetus with head presentation and average biometric and Doppler values up to the point. Her blood tests revealed an average complete blood count but increased liver enzymes. Total and direct bilirubin levels: 1.4 mg/dl
Serum amylase: 160u/l

Therapeutic interventions:

Pancreatitis during pregnancy is treated with Antibiotics, intravenous fluids, and the painkiller Inj. Pethidine. Were initiated as part of the medical therapy in this case. She complied with all therapy recommendations, and the results were positive.

Discussion:

A combination of clinical symptoms, laboratory tests, and radiographic examinations was used to diagnose pregnancy, and Acute Pancreatitis can occur. A multidisciplinary team should treat for the Acute Pancreatitis during pregnancy, and depending on the severity of the symptoms and the mother's and fetal's overall health, treatment options include conservative therapy or surgical intervention.⁵⁻¹¹

Due to a deficiency of documentation-based therapeutic guidelines and a lack of understanding of the link between acute Pancreatitis and pregnancy, rare cases of acute Pancreatitis in pregnancy and complex illnesses to handle. According to a revision of the Atlanta classification, the severity of symptoms was used to detect acute Pancreatitis in pregnancy¹²⁻¹⁷.

Except for pregnancy, none of these risk factors was mentioned in our case's history. Gastralgia (89.47 percent) and hyperemesis (68.42 percent) are the most common complaints and are the most prevalent clinical symptoms in pregnant women with acute Pancreatitis². Fever and anorexia are common signs and symptoms. Bowel noises may be diminished due to paralytic ileus, and an optimistic Murphy's character could present. Pneumonia affects ten percent of the population of the population¹⁸⁻²¹.

Nausea, vomiting, stomach pain, and other pregnancy symptoms are all common. Furthermore, because of the structural, The pregnant uterus that is trapped between the sacral promontory and pubic symphysis causes the abdominal organs to be displaced. Clinical examination of the abdomen in pregnancy is perplexing and complex.

Because some haematological and biochemical markers of acute Pancreatitis are the same as those observed in normal pregnancies, further testing is required to establish the diagnosis. The diagnostic sensitivity of a high blood amylase level is 81 percent, and serum lipase enhances the sensitivity to 94 percent²¹⁻²⁵. The treatment of acute Pancreatitis in pregnancy may depend on the seriousness of the condition, fetal age, common bile duct dilatation, inflammation of the bile duct, and gestational age¹. The topic of antibiotics is contentious. The results showed that prophylactic antibiotic use did not lower mortality, prevent gangrene, or diminish the need for surgical intervention.²⁶ The topic of antibiotics is contentious. The data show that preventing infections with antibiotics did not cut mortality, prevent infected necrosis, or lessen the need for surgical intervention.²⁷ For milder cases, the literature recommends conservative treatment²⁸.

Conclusion:

Finally, Early detection of pregnancy-related acute pancreatitis and conservative treatment with careful maternal and foetal monitoring are advised for the best outcomes. Only in exceptional cases and after thorough consultation with a multidisciplinary team may surgical treatments be used. Scientific societies and committees should concentrate on setting precise criteria for treating the condition rather than relying on expert opinions, case studies, or case reports due to the intricacy of acute Pancreatitis during pregnancy.

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