International Journal for Multidisciplinary Research (IJFMR)
E-ISSN: 2582-2160 ● Website: www.ijfmr.com ● Email: editor@ijfmr.com

A Case Report -Lateral Pancreaticojejunostomy for Pancreatic Duct Stones

Dr Ravi shankar[1], Dr Navneet Kumar Dubey[2]

[1]Associate Professor, Department general surgery, united institute medical science
[2]Assistant Professor, Department general surgery, united institute medical science

INTRODUCTION

Acute pancreatitis is an inflammation of the pancreas. [1] Medical management of this condition includes, control of pain and prescription of the pancreatic enzyme supplementation. Surgical treatment of this condition includes, celiac plexus Block, Frey's procedure and Lateral Pancreatojejunostomy. We present a case of 15 years female who had stones in the main pancreatic duct for which Lateral Pancreatojejunostomy was done successfully.

CASE REPORT

A male patient of 15 years was admitted in our surgical unit as an already diagnosed case of chronic pancreatitis on the basis of the history, examination and available investigations. A 15 years female with acute pancreatitis .

He was suffering from the episodes of the abdominal pain on the background of the continuous pain for the last 3 month. Pain radiated through the right side of the abdomen to the back and was associated with nausea, partially relieved by the injectible analgesics and aggravated by food ingestion. Moreover history of the abdominal trauma in the past was absent. Patient had many admissions in different hospitals for the recurrent attacks of the pain. But apart from this illness, he had never been to hospital for any other medical or surgical condition. He was on Analgesics and pancreatic enzyme supplementation and had never been allergic to the exposed medications.

Family history and the systemic inquiry were unremarkable except for occasional bouts of cough with sputum and occasional steatorrhea. Examination revealed an emaciated man looking older than his chronological age, having pallor but no clinical evidence of jaundice.

Abdominal examination showed no remarkable findings. Rest of the physical examination was normal. Patient was investigated which showed anemia, raised levels of blood sugar but normal values of serum amylase, renal function tests and Liver Function Tests (LFT's). Chest X-Ray and ECG were normal.

Under G/A upper midline laparotomy was done. Opening the gastrocolic ligament exposed area of the pancreas. Main pancreatic duct was opened after confirming it by aspirating the pancreatic juice. Stones were removed in. USG showed enlarged pancreas with 8.4MM cm dilated main pancreatic duct, full of multiple stones but with no evidence of dilatation of extra hepatic or intra hepatic billiary channels. Although B-mode ultrasonography is thought to be the best choice for the diagnosis of pancreatolithiasis [2],

CT abdomen was done, the objective of which was to rule out other associated pathologies like pancreatic pseudo-cyst and pancreatioplueral, pancreatogastric or pancratocolonic fistulae as surgical procedure would have been different in the presence of any of the complications. CT confirmed the findings of the

USG. Preoperatively patient was managed to improve the nutrition and anemia and Under G/A upper midline laparotomy was done. Opening the gastrocolic ligament exposed area of the pancreas. Main pancreatic duct was opened after confirming it by aspirating the pancreatic juice. Stones were removed .Main pancreatic duct with stone being delivered Stones removed from the pancreatic duct Roux-en- voy loop was mobilized and anastomosed with the dilated pancreatic duct (in two layers with silk 3/0 (LPJ). End to side jejuno-jejunal anastomosis was done. Drains were placed in the areas of the anastomosis and wound closed in layers. In the ward, post-op management was done by N/G aspiration(Fig-7), fluids, antibiotics, insulin therapy, monitoring B.P. pulse, drain outputs, urine output and by specifically looking for complications like anastomotic leak, wound or drain site infection. Recovery of the patient had been excellent with subjective declaration of the

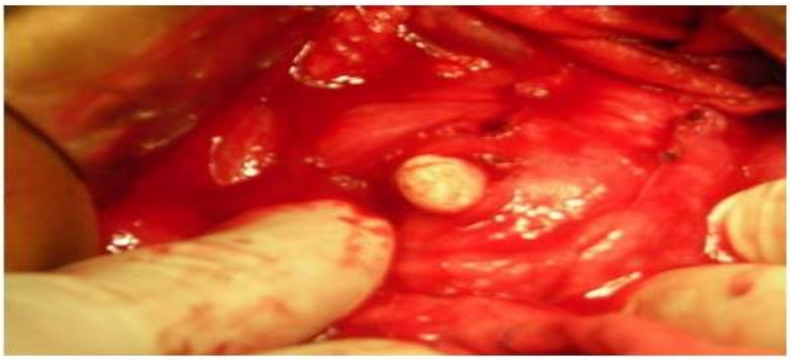

Fig- 4: Main pancreatic duct with stone being delivered

DISCUSSION

Possible genetic defects include mutations in pancreatic secretory trypsin inhibitor, cationic trypsinogen (PRSS1) and cathepsin B (CTSB) [3]. There is increased incidence of early onset diabetes in such patients [1]. Both medical and surgical treatments have their roles to play in chronic pancreatitis. Frey procedure, pancreaticodudene-ctomy, distal pancreatectomy and Lateral pancreaticojejunostomy are various surgical options available with with variable success rates. Lateral pancreaticojejunostomy is usually performed to relieve the pain intractable to the medical management[4]. We also found it effective for our patient. Adamas DB et al, Andresson et al and Kalddy et al [4,5] in their case series reported it as a safe and effective way of relieving pain substantially and completely in 65-85% of the cases.

The complications that may arise in postoperative period include upper GI Haemmorage, pancreatic fistulae and wound infection. The over all morbidity rate is 5.9% reported in literatue [4]. Long-term complications include recurrent attacks of the pain and continued use of insulin and pancreatic enzymes due to derangement of the endo and exocreine function. Anderssan et al [5] in their study reported that deterioration in the abdominal pain in long term follow up .

CONCLUSION

Tropical calcific pancreatitis, an inflammatory condition of the pancreas, is usually associated with the pancreatic duct stones for which lateral pancreaticojejunostomy provides excellent results with acceptable early morbidity and mortality. Further studies are needed to establish the long-term outcome of the procedure when done specifically for this condition.

REFERENCES

1. Russell RCG, Williams NS, Bulstrode CJK. Bailey & Love's short practice of surgery. 24th ed. London: Arnold Hodder, 2004:1114-32.
2. Wei Y, Li WS, Ali U, Guang LQ, En PC. The diagnosis and treatments of pancreatolithiasis with pancreatic cancer. Pak J Pathol 2001;12:23-6.
3. Mahurkar S, Idris MM, Reddy DN, Bhaskar S, Rao GV, Thomas V, etal. Association of cathepsin B gene polymorphisms with tropical calcific pancreatitis, Gut 2006;55:1270-5.
4. Adams DB, Ford MC, Anderson MC. Outcome after lateral pancreaticojejunostomy for chronic pancreatitis. Ann Surg 1994;219:481-9
5. Andersson R, Borjesson A, Blind PJ, Tingstedt B. Pancreaticojejunostomy: a valid operation in chronic pancreatitis? Scand J Gastroenterol 2008; 43:1000-3.