Abstract:
Acute pancreatitis is an under diagnosed cause of upper abdominal pain in pregnancy. Herewith we are presenting a case of acute pancreatitis in pregnancy in a 24 year old G2P1L1 which was managed with octreotide with good maternal and perinatal outcome. So far less than 100 cases of acute pancreatitis have been reported in the literature that have been managed with octreotide.

Keyword: acute pancreatitis in pregnancy, octreotide, amylase, lipase.

INTRODUCTION:
Acute pancreatitis in pregnancy has an incidence of 1 in 4000 pregnancies. It is under diagnosed and has high maternal and fetal mortality if unrecognised.

CASE REPORT:
A 24 years gravid 2 Para 1 living 1 , not sure of dates was referred from a private hospital on 21st July 2010 with complaints of pain in the upper abdomen for 1 day. The pain was aggravated only supine, relieved on bending forwards, not radiating. She had complaints of vomiting for 8 episodes, immediately after taking food, not bile stained. No history of hematemesis. No history of bladder and bowel disturbance. No history of trauma, bleeding or draining per vaginum. Perceives fetal movements well. She had a full term normal delivery 2 years back. There was no relevant family history. On examination, she was not anaemic, not icteric, hydration fair, vitals stable. Uterus was term size, not tense, not tender, cephalic presentation. Tenderness in epigastrium and left hypochondrium felt. Fetal heart beats were regular. On vaginal examination, cervix was uneffaced, os closed, head at brim, pelvis was gynaecoid. Investigation showed haemoglobin 10g%, total count 9800 cells/mm3, differential count P 70, L 28 , E 2, platelets 1 lac/mm3. Serum amylase 4157 U/l, serum lipase 3183.8 U/l, blood sugar 68 mg%, urea 18 mg%, creatinine 0.8 mg%.
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serumbilirubin 1 mg / dl , SGOT 28 u / l , SGPT 18 U / l , ALP 112 U / l , triglycerides 175 mg / dl , cholesterol 100 mg / dl , serum proteins 6 gm% , serum calcium 7.8 mg %.

Ultra sonogram showed single live intra uterine gestation corresponding to term, with cephalic presentation, fetal heart rate 142 beats per minute, regular, AFI 16.5. Gall bladder was partially distended and grossly normal. Pancreas was bulky with mild heterogeneous echogenicity. Mild free fluid in abdomen noted. Features suggested acute pancreatitis.

She was started on intravenous fluids, analgesics, antibiotics, Ryles tube aspiration and charts were maintained. Nilper oral maintained. Injection octreotide 100 microgram givensubcutaneously 8 th hourly. Repeat enzyme levels on 26 th July2010 was serum amylase 191 u/l , serum lipase 168.5 u/l. on 26 th July PGE2 gel instilled for preinduction ripening of cervix. On 27 July induction of labour done with oxytocin. As labour didn’t progress, emergency LSCS was done on 27 th July to deliver a live term boy baby of wt 2.5 kg at 7.50 pm. Post operative period wasuneventful. Ultrasound on 10 th day showed pancreas diffusely enlarged, no fluid collection, no internal changes. Patient discharged on 11 th day. Serum amylase 72 u/l , serum lipase 60 u/

DISCUSSION: Acute pancreatitis is the acute inflammation of pancreas presenting with abdominal pain associated with increased enzyme levels. It affects 1 in 4000 pregnancies and more common in third trimester. It is caused by alcohol, gall stones, collagen vascular disease, hyperparathyroidism, hyperlipidemia, trauma, infections, familial, genetic, idiopathic. It presents with severe upper abdominal pain, radiating to the back, vomiting, fever, epigastric tenderness, jaundice, shock, signs of intraperitoneal hemorrhage. There is a fall in haemoglobin with elevation of serum amylase and lipase, serum calcium and serum proteins. Ultrasound shows pancreatic edema, fluid in abdomen, biliary- tract disease. X ray abdomen shows colon cut off sign, sentinel loop sign. Management is conservative with Ryles tube aspiration, antibiotics, analgesics, aggressive fluid replacement and injection octreotide. The complications include pseudocyst, pancreatic abscess, shock, perforation of stomach, hypocalcemia, hyperglycemia, hypertriglyceridemia, encephalopathy, pleural effusion, ARDS, MODS. It causes preterm labour, fetal wastage. Maternal mortality is low in uncomplicated cases, 1% in complicated pancreatitis.

OCTREOTIDE: It is a somatostatin analogue. First synthesised by Wilfred Bauer in 1979. Chemical formula is C 49 H 66 N 10 O1S2. 100 % bioavailability by subcutaneous route. Removed by hepatic metabolism. In pregnancy it is a category B drug. Dose is 50 to 100 microgram 8 th hourly. It inhibits the secretion of gastrointestinal hormones, intestinal and pancreatic fluids, decrease gastrointestinal motility, inhibit contraction of gall bladder, decrease portal pressure in bleeding varices, causes vasoconstriction and analgesia.

It is used in acromegaly, carcinoid, severe refractory diarrheas, VIPomas, pancreatitis, oesophageal varices, thymic neoplasms, malignant bowel obstruction, decrease pain associated with hypertrophic pulmonary osteoarthropathy. Its adverse effects are abdominal p
ain, bradycardia, cardiac conduction changes, dyspepsia, flatulence, hypothyroidism, steatorrhea, biliary calculi, and hyperglycemia and injection site reactions.

REFERENCES:
