

## Case Report

# Acute pancreatitis Masquerading as acute appendicitis – A diagnostic dilemma

Nitin wasnik<sup>1</sup>, Vijay P Agrawal<sup>\*2</sup>, Kunal R<sup>3</sup> and Vinay Khatri<sup>4</sup>

<sup>1</sup>Associate professor, Dept. of General Surgery, NKPSIMS, Nagpur.

<sup>2</sup>Senior resident, Dept. of General Surgery, NKPSIMS, Nagpur.

<sup>3</sup>JR3, Dept. of General Surgery, NKPSIMS, Nagpur.

<sup>4</sup>JR2, Dept. of General Surgery, NKPSIMS, Nagpur.

### \*Correspondence Info:

Dr. Vijay P Agrawal

Senior resident,

Dept. of General Surgery,

NKPSIMS, Nagpur.

Email id: [vijugunnu@gmail.com](mailto:vijugunnu@gmail.com)

### Abstract

We present a case of acute pancreatitis mimicking as acute appendicitis. There are very few cases in the literature suggesting acute pancreatitis leading to the development of ascities and features of acute appendicitis. The patient was initially diagnosed as complicated acute appendicitis but after thorough workup revealed acute pancreatitis and managed successfully by conservative management.

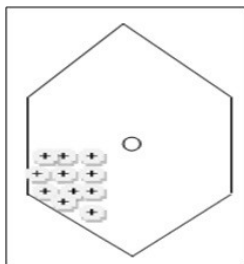
**Keywords:** Acute abdomen, acute appendicitis, acute pancreatitis

## 1. Case report

A 28 year old male came to causality with pain in abdomen localising to right iliac fossa for 2 days. There was history of severe nausea but no vomiting and fever. There was no history of similar complaints in the past. Patient was an occasional drinker and denied alcohol consumption for the last 6-7 months. The patient gives history of admission to some hospital with acute abdomen for drinking in excess 8 months back with no details available. There was no significant surgical history.

On examination patient was febrile with a temperature of 38.6 and was tachycardic with a pulse of 110 beats per minute. There was severe tenderness in the right iliac fossa with rebound tenderness and peritonism, consistent with a diagnosis of acute appendicitis. (Fig-1) The other systems were normal. It was also kept in mind that he was previously admitted in emergency with acute abdomen probably with acute pancreatitis or acute gastritis.

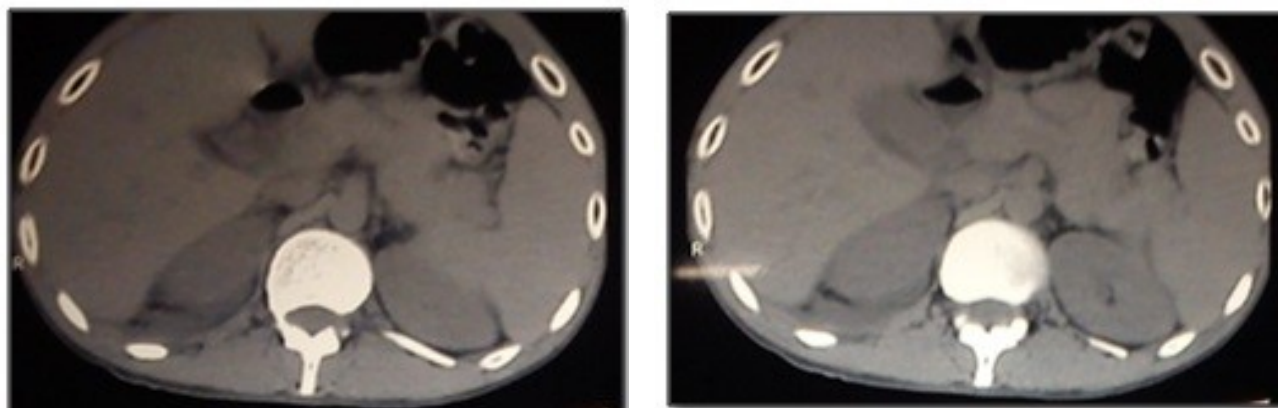
**Fig 1- Site of tenderness**



Blood investigation revealed normal blood counts. Liver function test was normal. His amylase and lipase level was sent. Erect X-ray was normal. Ultrasound abdomen revealed features of cholecystitis and mild ascities. With such a confusing investigational findings which was not corresponding with the clinical diagnosis CT scan abdomen was planned.

CT abdomen revealed bulky and heterogenous pancreas with associated with peri-pancreatic fat stranding and fluid collection suggesting acute pancreatitis, mild ascities and hepatomegaly. (Fig-2, Fig-3)

**Fig 2 & 3- CT abdomen showing features of acute pancreatitis.**



Amylase level came as 365.8 units/L and lipase level as 147.8 units/L additionally confirming the diagnosis of acute pancreatitis.

Patient was managed conservatively with nil per oral along with IV fluids, proton pump inhibitors, somatostatin analogue and analgesic SOS for 3 days. Patient was started oral liquids on 4<sup>th</sup> day and full diet from 6<sup>th</sup> day. Patient was discharged on 10<sup>th</sup> day and is on follow up since 1 month without any similar complaints.

## 2. Discussion

Our case presented with acute abdomen, provisionally diagnosed to have complicated acute appendicitis. The patient was planned for emergency appendectomy. But after investigations and work up final diagnosis was acute pancreatitis with mild ascities with hepatomegaly. Hence surgery was avoided and patient was managed conservatively.

The reason for presenting this case was to point out the necessity of thorough history, clinical findings along with necessary investigations helps to prevent negative appendectomy/laprotomy.

The underlying cause should be addressed whenever feasible. In patients with an acute abdomen, immediate exploration should be performed. Laparotomy usually allows a definitive diagnosis and provides an opportunity to address the underlying cause.<sup>1</sup>

Our case had mild ascities, we don't know whether it was chylous and due to pancreatitis. Literature suggests pancreatitis is a rare cause of chylous ascities.<sup>2,3</sup>

The surgeon's aim is to correctly diagnose the appendicitis and therefore to minimize the negative appendectomy rate without increasing the incidence of perforation.<sup>4</sup> He has to evaluate a diverse group of patients who present with abdominal pain and has to consider different aetiologies.<sup>5</sup> The goal of a diagnostic accuracy approaching 100% sensitivity and specificity should be reached in a time, cost, and consultation-efficient manner.<sup>6</sup>

CT scan is more accurate than ultrasound for the diagnosis of appendicitis in adults and adolescents. CT scan has a sensitivity of 94%, specificity of 95%. Ultrasonography had an overall sensitivity of 86%, a specificity of 81%.<sup>7</sup> In 2006, a meta-analysis by Doria et al. demonstrated that CT imaging featured significantly higher sensitivity and resolution than ultrasound in studies of both children and adults with acute appendicitis.<sup>8</sup> The use of CT for diagnosis of appendicitis in Boston, MA has decreased the chance of finding a normal appendix at surgery from 20% in the pre-CT era to only 3% according to data from the Massachusetts General Hospital.<sup>9</sup>

Computed tomography is considered the gold standard in diagnostic imaging for acute pancreatitis.<sup>10</sup> The management of acute pancreatitis includes pain control, bowel rest, and nutritional support. Antibiotics and surgery is required if there is pancreatic necrosis.

### 3. Conclusion

Meticulous history, clinical examination, blood investigations and radiological investigations like CT abdomen (gold standard) help to diagnose acute pancreatitis and prevent negative surgery. Above case was initially diagnosed as complicated acute appendicitis but finally landed up in acute pancreatitis and thus managed conservatively and preventing negative appendectomy/laprotomy.

### References

1. Fang FC, Hsu SD, Chen CW, Chen TW. Spontaneous chylous peritonitis mimicking acute appendicitis: a case report and review of literature. *World J Gastroenterol* 2006; 12: 154-156.
2. Aalami OO, Allen DB, Organ CH Jr. Chylous ascites: a collective review. *Surgery* 2000; 128: 761-778.
3. Goldfarb JP. Chylous effusions secondary to pancreatitis: case report and review of the literature. *Am J Gastroenterol* 1984; 79: 133-135.
4. <http://www.guideline.gov>
5. Sedlak M, Wagner OJ, Wild B, Papagrigoriades S, Exadaktylos AK: Is there still a role for rectal examination in suspected appendicitis in adults? *Am J Emerg Med* 2008, 26(3):359-360
6. Niwa H, Hiramatsu T: A rare presentation of appendiceal diverticulitis associated with pelvic pseudocyst. *World J Gastroenterol* 2008, 14(8):1293-1295.
7. Terasawa T, Blackmore CC, Bent S, Kohlwes RJ (2004). "Systematic review: computed tomography and ultrasonography to detect acute appendicitis in adults and adolescents". *Ann. Intern. Med.* 141 (7): 537–46.
8. Doria AS, Moineddin R, Kellenberger CJ, Epelman M, Beyene J, Schuh S, Babyn PS, Dick PT: US or CT for diagnosis of appendicitis in children and adults? a meta-analysis. *Radiology* 2006, 241:83-94. .
9. <http://www.parasitetesting.com/Appendicitis.cfm>
10. Arvanitakis M, Koustiani G, Gantzarou A, Grollios G, Tsitouridis I, Haritandi-Kouridou A, Dimitriadis A, Arvanitakis C (2007). "Staging of severity and prognosis of acute pancreatitis by computed tomography and magnetic resonance imaging-a comparative study". *Dig Liver Dis.* 39 (5): 473–482