SHARED LEARNING EVENT

JULY 2016

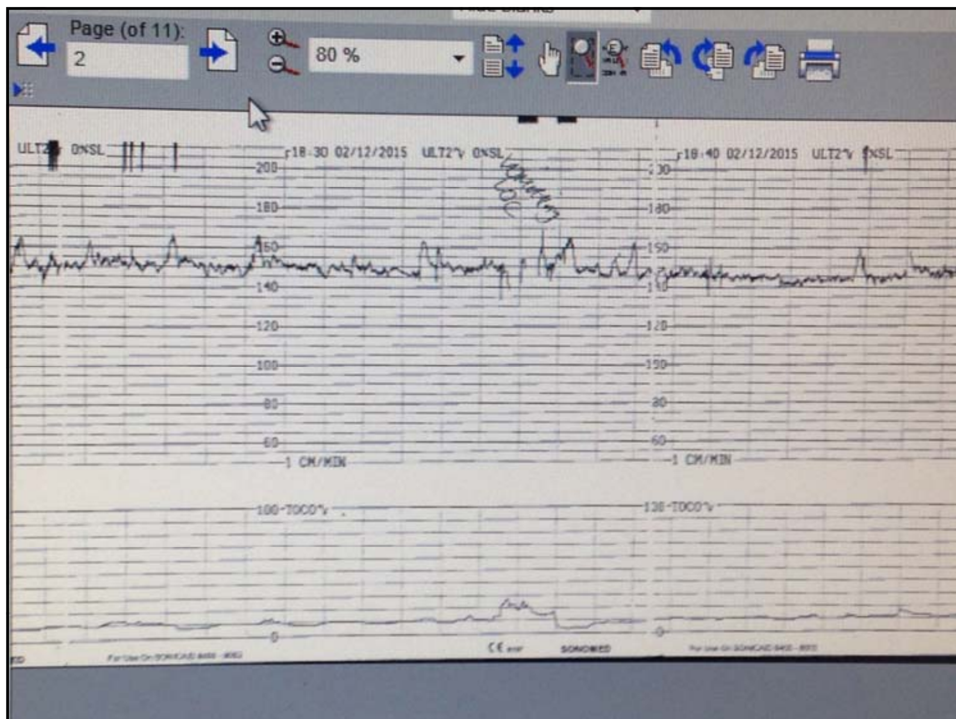
S. Ibrahim
A.Siddharth,
M.Pezeshki

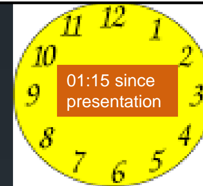
History

- 26 year old
- Primigravida
- Fit and Healthy usually
- 37 + 5 /40

Presenting complaints, 02/12/2015 , 17:45

- Presented to ADAU (transferred from A&E)
- c/o Abdominal pain & vomiting since 6 am
- No diarrhea
- Normal fetal movements/ no PVB/no SROM





2/12/15, 19:00

- Registrar busy in theatre, sister in charge consulted.

- Patient admitted
- IV access, fluids
- FBC, CRP , U&E

19:15, 2/12/15:

R/V by Registrar

CTG continued for 1 hour after- normal

3/12/15, 06:20
Review by Oncall Registrar

- No Oral food/ drink > 24 hours.

- Has received 3 L fluids iv, cyclizine in hospital

- At present
  - No more vomitting
  - Increased Temp
  - Epigastric pain +
  - **No loose stools**

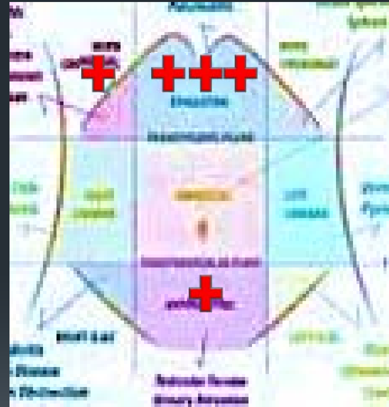
3/12/15 06:20, Registrar review contd

Abdomen:

Epigastric tenderness ++

No generalized tenderness

Some tenderness in Right hypochondrium & suprapubic



3/12/15, 06:20, Registrar review contd.

Plan

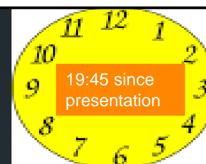
Continue Observations, CTG for 20 mins

Continue Fluid balance

IV Fluid/ Antiemetic

Rpt FBC/ LFT/ U&E/ CRP/ **Amylase**

3/12/15 13:30, Consultant ward round

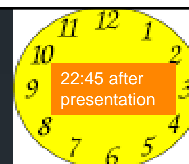


Blood test reports:

AST- 65
Total Bil- 31
GGT 22
WCC 13.3
Hb 85

- Imp: ?Viral infection/ ?Hepatitis

03/12/15, 16:30 Registrar review



Plan:

Shift to Labour room

Surgical review

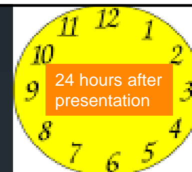
May need Induction of Labour if patient deteriorates (Consultant contacted and plan agreed upon)

3/12/15, 17:45, Consultant review

Duty Radiologist consulted

- No urgent need for an USS as its unlikely to alter management.
- For USS tomorrow
- not for MRCP yet

3/2/15, 17:45 Surgical Registrar review



Plan:

- Glasgow scoring to determine risk of developing severe pancreatitis
- USS abd for GB/CBD stones
- Lipid profile
- IV fluids , catheterize for input output chart
- Nil by mouth

- Patient debriefed about diagnosis and plan

GLASGOW SCALE

PaO2	<8KPa
Age	>55 years
Neutrophils	>$15x10^9$/L
Calcium	<2mmol/L
Renal Function	Urea >16mmol/L
Enzymes	LDH >600iU/L / AST >2000iU/L

3/2/15, 22:00 Registrar review

- Shortness of breath since yesterday
- Very tender in the abdomen, restricting movement
- Glasgow Score- 2 (increased WBC, decreased Albumin)
- Urine output 28/20/80 mls in the last 3 hours, positive balance
- RR 34

3/2/15, 22:00, Registrar review

Plan
No indication for diuretics at present

Surgical Registrar to review again

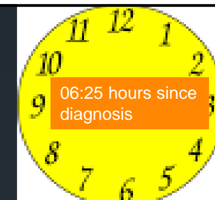
Calcium levels to be checked

Chest X ray

ARM if induction is needed

Rpt bloods in 6 hours .
Recalculate glasgow score in 6 hours- if >3, for ITU care

4/12/15, 00:10 Surgical Registrar review

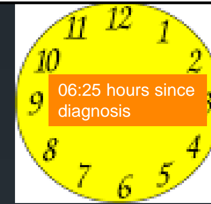


Deterioration in condition
- Increased RR (40/min)
- Increased HR (100/ min)
- Poor urine output (20 mls/ hr)

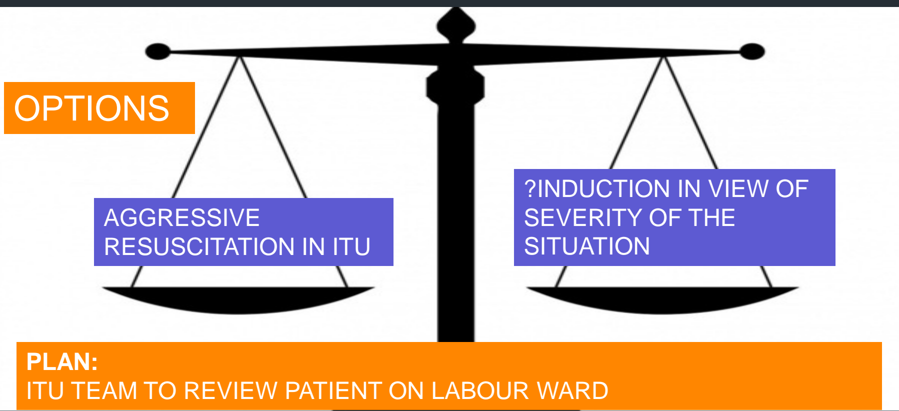
Severe pain and discomfort, making movement very difficult

Glasgow score - 2 this afternoon (Ca, WBC)- needs repeat scoring in a few hours

4/12/15, 00:10
Surgical Registrar review

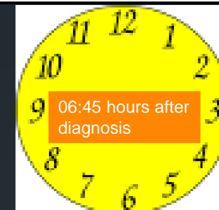


- Extensive discussion with Gynae Registrar and senior midwife



PLAN:
ITU TEAM TO REVIEW PATIENT ON LABOUR WARD

4/12/15,00:30
Gynae Registrar review

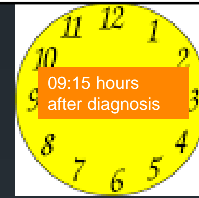


- RR 40/min, PR 110/min, BP normal
- Urine 38 ml/hr
- Positive balance- 1800 mls

Patient needs stabilization prior to delivery.

Consultant review requested as needs admission to ITU & plan for delivery

4/12/16, 03:04
Urgent LSCS



- Cat 2 LSCS as patient was unstable
- Routine section performed by consultant
- EBL 400 mls
- Baby was born healthy
- Post op care in ITU

In ITU from 4/12/15 to 7/12/15

Stepped down to Labour room on 7/12/15

Readmitted to ITU - 8/12/15

Respiratory support weaned down over 48 hours, until maintaining sats on air

Inflammatory markers settling but still spiking temp

Likely SIRS related to pancreatitis

MRCP on 9/12/15

- Gall stone pancreatitis confirmed
- Thin walled gall bladder , mild CBD dilatation

On the ward from 10/12/15

- Low grade temperature for a few days
- Inflammatory markers improved with antibiotics and patient became afebrile
- Repeat CT Abdo Pelvis- 14/12/15- Maturation of inflammatory changes to the pancreas with potential development of peripancreatic collection

Discharged on 16/12/15

Plan:

- Outpatient CT in 3 weeks
- Review in surgical outpatient clinic with report to plan for a laparoscopic cholecystectomy.

Follow up

- Laparoscopic Cholecystectomy on 11/1/16
- Routine procedure.

ACUTE PANCREATITIS IN PREGNANCY

- 1 out of every 10,000 pregnancies (1)
- Most cases of acute pancreatitis in pregnancy are caused by gallstone disease. (Next most common-hypertryglyceride induced)
- Maternal mortality is less than 1% for acute pancreatitis in pregnancy.
- The rate of pre-term delivery, however, is about 20%.

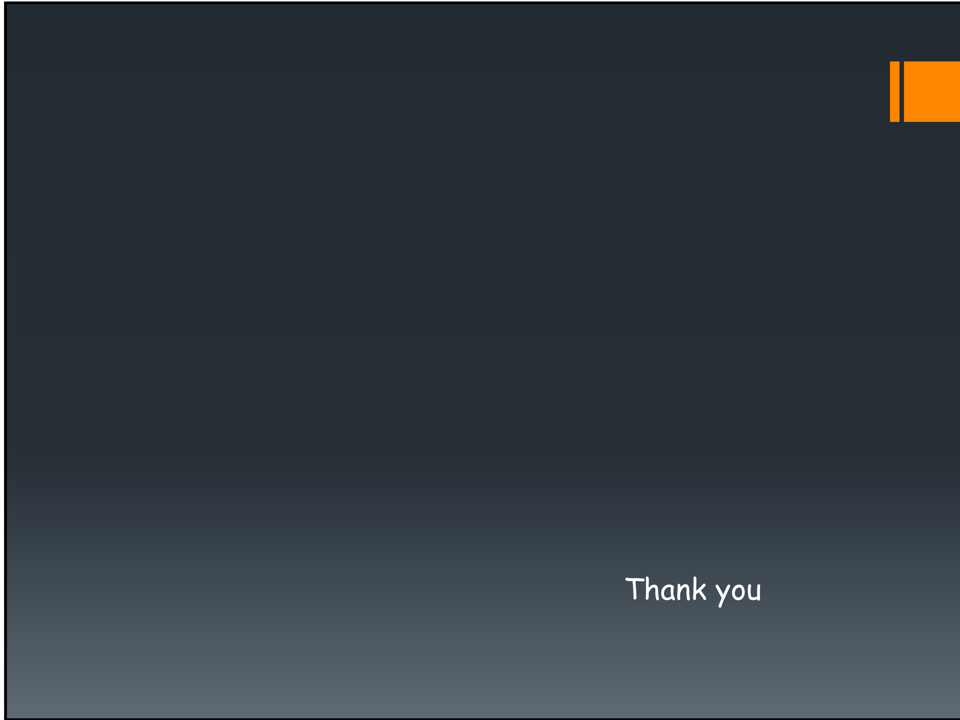
UK guidelines on management of acute pancreatitis

UK working party on Acute pancreatitis , revised 2003

- Correct diagnosis of pancreatitis should be made within 48 hours of admission
- Glasgow score of > 3 can be used as a prognostic feature to predict complications with acute pancreatitis
- Evidence to use antibiotics to prevent infection from necrotising pancreatitis is conflicting. Some trials show benefit , others don't
- Urgent early ERCP for those proven or highly suspicious to be caused by gall stone disease and is best carried out within 72 hours of onset of pain

UK working party on Acute pancreatitis , revised 2003

- After an attack of mild pancreatitis, patients with gallstone disease must undergo definitive treatment in order to prevent recurrence with severe and life threatening pancreatitis
- In severe pancreatitis , cholecystectomy should be delayed until signs of lung injury and systemic disturbances have resolved. For mild pancreatitis, ideally, cholecystectomy should not be delayed for longer than 2 weeks post discharge from hospital
- Management of pancreatitis is supportive. Severe pancreatitis must be managed in units with HDU facilities to provide organ support


Thank you