Chapter 49
Case on Intra-abdominal Bleeding with Shock as Consequence of Necrotizing Pancreatitis

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Keywords Acute Necrotizing pancreatitis • Intra-abdominal bleeding • Hypovolemic Shock • Gallstones

Diagnosis and Indication for Surgery

A 55-year-old man was presented to the First Aid department because of abdominal pain and shock.

Patient was resuscitated by intubation and ventilation, and abundant fluid reposition. His amylase in serum was high (2,500 U/ml), and the possibility of his having an acute pancreatitis rose. A CT scan confirmed acute pancreatitis, Balthazar type C with gallstones, and no aneurysm of the abdominal aorta (Fig. 49.1a). He was admitted to the Intensive Care department and the following day he developed a hypovolemic shock with low hemoglobin rate. An angiography showed no blush and no aneurysms in the visceral arteries (Fig. 49.1b). Because of hemodynamic instability, the surgeon decided to operate him.

Operation

At laparotomy, an acute necrotizing pancreatitis was found with abundant blood and clots in the lesser sac. A central bleeding was observed possibly coming from the left of the celiac trunk, possibly a pseudoaneurysm of the splenic artery, and different stitches were done to fix the bleeding.

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M.A. Cuesta, H.J. Bonjer (eds.), *Case Studies of Postoperative Complications after Digestive Surgery*, DOI 10.1007/978-3-319-01613-9_49,

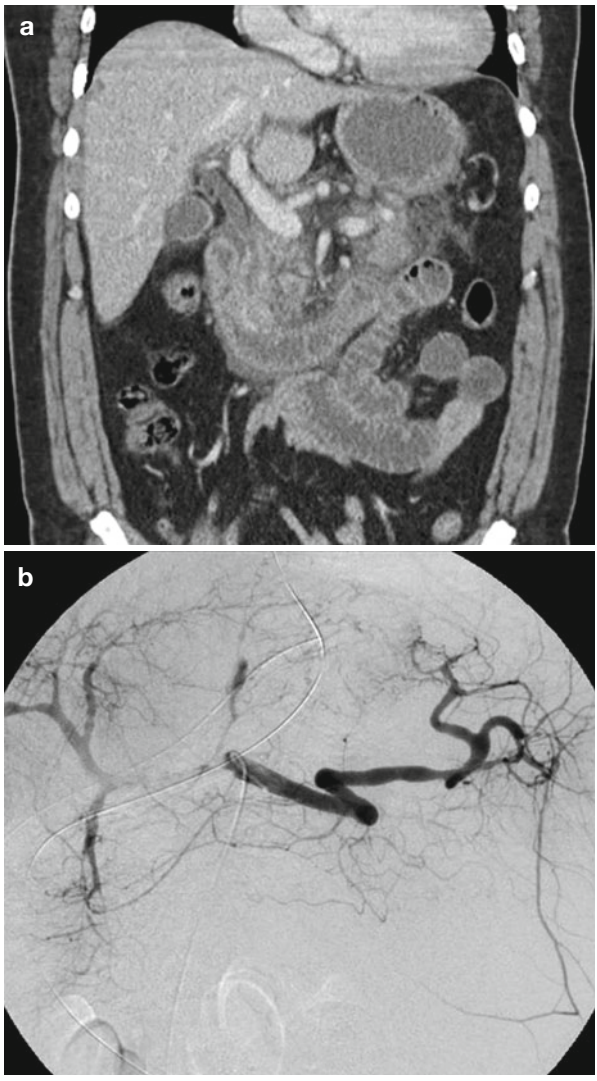

Fig. 49.1 (**a**) CT scan on admission acute pancreatitis and cholelithiasis. No aorta aneurysm. (**b**) Angiography of celiac trunk and SMA, no blush

Postoperative Course and Identification of the Complication

The patient was mechanically ventilated and the sepsis treated by iv broad spectrum antibiotics, iv noradrenaline and total parenteral nutrition. His wound became infected and dehiscent and abundant pus drained spontaneously. Vacuum system therapy was considered but because of the presence of bowels on the surface of the wound was not performed. Wound cleansing was performed. During the course of 6 weeks, because of the low-grade septic situation, various CT scans were performed in which different intra-abdominal abscesses were percutaneously drained

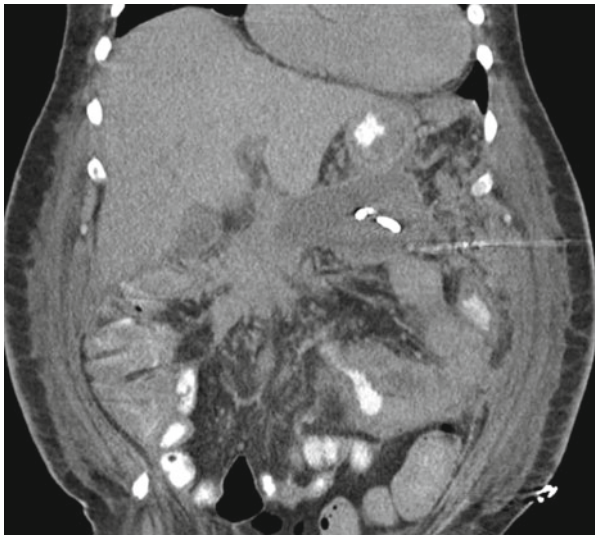

Fig. 49.2 Central abscess in pancreas, percutaneously drained

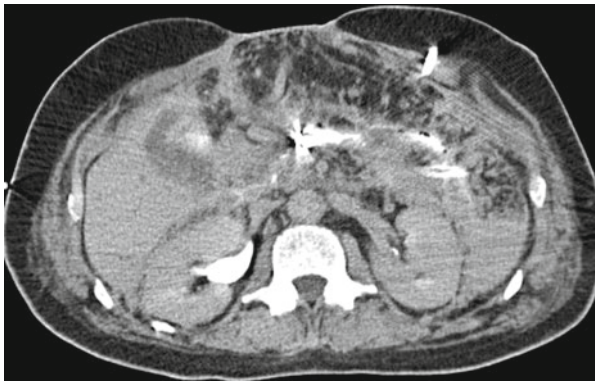

Fig. 49.3 Abscesses are becoming quite. Open abdomen approach

(Fig. 49.2). After a long period of 4 months during which he developed psychosis with deliriums, he was admitted to the psychiatric unit at the hospital. He recovered completely (Fig. 49.3) and 3 months later a cholecystectomy and repair of the cicatricial hernia by means of polypropylene mesh were performed.

Discussion

The lesson of this case is that at presentation, a differential diagnosis was made between rupture of aorta aneurysm or necrotizing acute pancreatitis. After resuscitation, a CT scan established the proper diagnosis. Because of intra-abdominal bleeding, an angiography was done without visualization of a blush. Intervention

was considered necessary because of no blush and hemodynamic instability. At emergency laparotomy, it was a difficult procedure to fix the bleeding. Consequently infection of the necrosis, multiple abscesses, open wound approach, and psychosis were adequately treated during a very long hospital stay. Mortality may be very high with this approach.