CR67 Recurrent acute pancreatitis

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KEYWORDS: CBD stenosis; pancreatitis; pancreatobiliary anomalies

INTRODUCTION/OBJECTIVES: Acute pancreatitis is an inflammation of the pancreas that is clinically characterized by severe abdominal pain, nausea and vomiting, combined with elevated serum digestive enzymes. The etiology of pancreatitis in children differs from adult patients with predominance of abdominal trauma (23%) and pancreatobiliary anomalies (15%) while in almost 25% of cases, the etiology remains unknown.
CASE PRESENTATION: We present a patient, now a 15-year-old girl who first presented at the age of 4 with abdominal pain, vomiting and laboratory findings of elevated aspartate transaminase (AST) and alanine transaminase (ALT). Ultrasound showed dilated intrahepatic and extrahepatic bile ducts. Endoscopic retrograde cholangiopancreatography (ERCP) revealed complete obstruction of common bile duct (CBD) and as a therapeutic measure a stent was inserted. The patient recovered completely, and the stent was removed three months later. This patient presented again with symptoms of pancreatitis at the age of 8 which resulted with insertion of 2 stents, one into the pancreatic duct and one into the CBD, followed by a complete recovery. After a year both stents were removed, and since then the girl didn't have new episodes, she is in good health without a strict diet. After several diagnostic procedures (magnetic resonance cholagiopancreatography, ERCP, liver biopsy) a diagnosis of congenital anomaly of pancreaticoduodenal junction was made.
CONCLUSION: Given the frequency of anomalies in pediatric patients with recurrent pancreatitis, developmental anomalies should be suspected. In this specific case, as the child developed, so did the bile ducts, and the stenting was just a method of temporarily relief. Now this anomaly is not interfering with normal bile outflow.

CR68 Senile purpura, disseminated intravascular coagulation or a crime scene?

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KEYWORDS: pneumonia; purpura; warfarin

INTRODUCTION/OBJECTIVES: In the background of seemingly harmless bacterial pneumonia, unresolved family problems are potentially the cause of a fatal outcome.
CASE PRESENTATION: We discuss the case of a 82-year-old female patient who came to the general practice complaining of fever, skin lesions and fatigue. The patient began experiencing symptoms ten days prior to admission. Past medical history showed arterial hypertension, permanent atrial fibrillation and COPD. She was taking ACE inhibitor, calcium-channel blocker, coumarin anticoagulant, anticholinergic agent and was on continuous oxygen therapy (1 L/min). She was presented with tachycardia (104/min) and low spot oxygen saturation (SpO2 82% without O2 and 88% with O2). Other vital signs were stable. Physical examination showed fine lung crackles at bases and tiny petechiae on both of her lower legs. ECG showed no gross abnormalities. Blood taken for the laboratory tests showed mild erythrocytosis, neutrophilia and elevated CRP. Her INR was around 3,4. She insisted to be treated with antibiotic and refused to be admitted to the hospital. Although blood tests taken four days after the doctor's visit showed improvement in differential blood count and CRP, she was admitted to the hospital because of INR > 6 and deteriorated general condition. It was later discovered that her husband was giving her twice the daily dose of warfarin in the last seven days which could have been the cause of purpura on the lower legs and intracranial bleeding later on.
CONCLUSION: In addition to a detailed auto- and heteroanamnesis, it is advisable to be familiar with the family situation so as not to overlook less probable causes of the disease.