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Case Report

HEMOSUCCUS PANCREATITIS: A RARE CAUSE OF CHRONIC – ANAEMIA

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ABSTRACT

Hemosuccus pancreatitis (HP) or Pseudohemobilia is diagnosed when there is hemorrhage from the pancreatic duct. It is most often associated with a pre-existing pancreatic disease process. In this case report we describe a patient with history of chronic pancreatitis who presented with malena since 3 months. After careful evaluation and hematologic workup showed anemia and normal coagulation profile. Upper GI endoscopy revealed blood clots at the Ampula of Vater. CT abdomen and CT Angiogram suggested chronic calcifying pancreatitis with splenic artery pseudoaneurysm communicating with the main pancreatic duct. He was diagnosed to have HP and managed with embolisation and blood transfusions. He showed a steady recovery and was discharged after four days of hospitalization. It is relevant to consider HP in patients with a history of malena and normal endoscopic findings.

Key words: Malena, Pancreatitis, Embolisation, Aneurysm.

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INTRODUCTION

Hemosuccus pancreatitis is a rare cause of gastrointestinal (GI) bleed and chronic anemia. The diagnosis is challenging since it is very rare and requires a high level of suspicion in patients with GI bleed. HP is usually associated with acute or chronic pancreatitis. Since the GI bleed is intermittent, the frequent upper GI endoscopy may be normal or colonoscopy may not reveal any blood in the intestines.

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CASE REPORT

A gentleman aged 42 years, a known alcoholic, smoker and hypertensive, was referred to our hospital following initial evaluation for complaints of vague upper abdominal pain and passing dark stools since 3 months. The patient was found to have anemia for which he received multiple blood transfusions and was later subjected to an upper GI endoscopy and colonoscopy. These studies were found to be normal. On arrival to our emergency room (ER), he was conscious, afebrile and maintained stable vitals such as heart rate (92beats/minute), blood pressure (90/50 mm Hg) and respiratory rate (24/min). The patient was shifted to MICU for further management. The patient claimed to have had similar abdominal pain in 2012. He was diagnosed as

Calculus cholecystitis and was managed surgically by open cholecystectomy. He also gave a history of recurrent chronic calculus pancreatitis and multiple admissions for the same. On physical examination, the patient was pale. Per abdomen exam revealed tenderness to palpation over the epigastric region. Other systemic examination was normal.

Laboratory findings showed hemoglobin of 5.3 grams/dl. Liver function test, renal function test, coagulation profile and serum electrolytes were within normal limits. His anemia was managed with multiple blood transfusions. An ultrasound of his abdomen showed multiple calcific foci involving the whole pancreas suggestive of chronic calcific pancreatitis. To investigate further, Upper GI Endoscopy was performed and revealed blood clot near Ampula of Vater (FIGURE-1). CT Abdomen with angiogram revealed pseudoaneurysm of the splenic artery (FIGURE-2) and pseudocysts communicating with the main pancreatic duct in addition to a bulky distal body and tail of pancreas with ductal and intraparenchymal calcifications. He was diagnosed to have HP and managed with coil embolization of the splenic artery (FIGURE-3). He showed a steady recovery and was discharged after four days of hospitalization.

Fig 1. Upper gastrointestinal endoscopy showing blood clot at Ampula of Vater

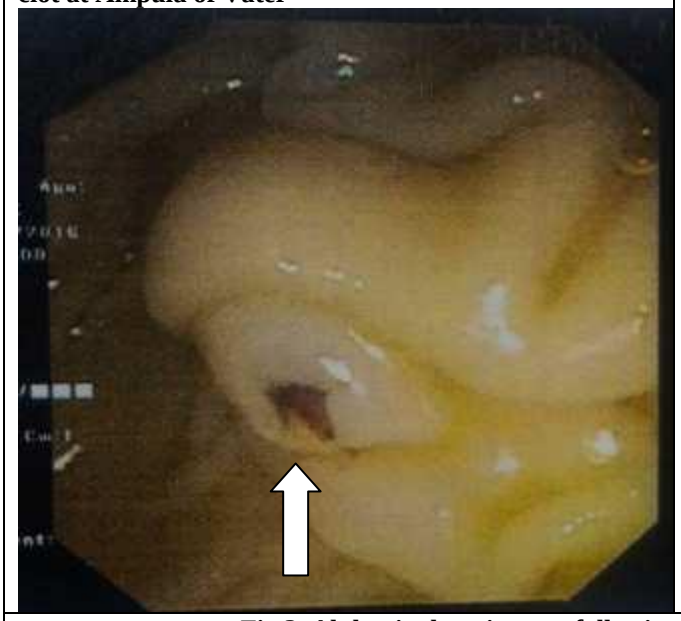


Fig 2. Abdominal angiogram showing splenic artery aneurysm

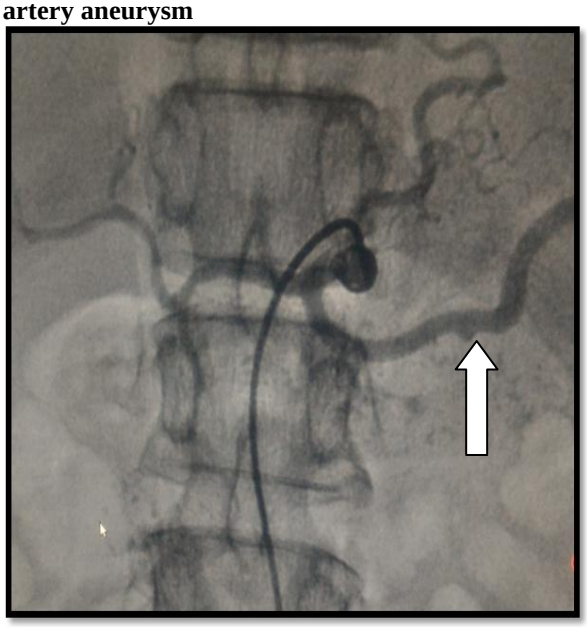
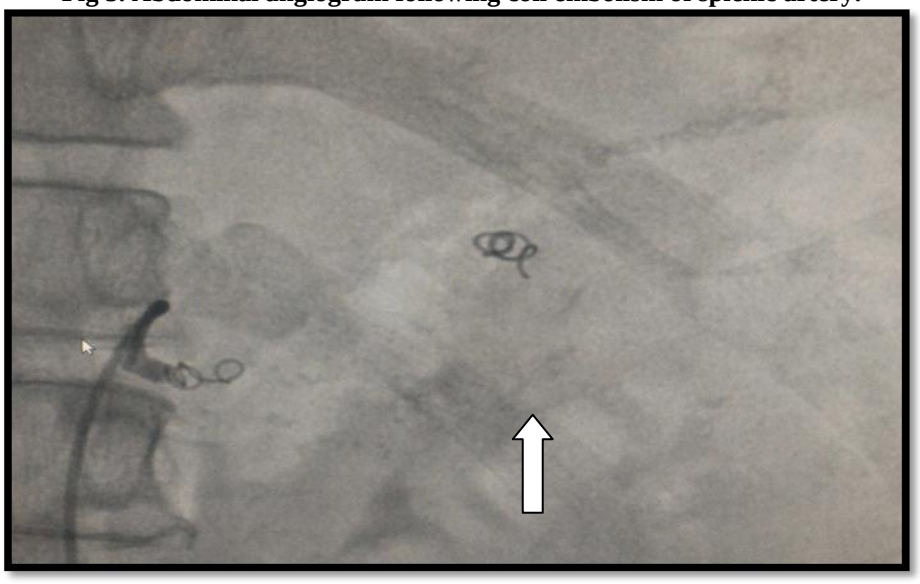


Fig 3. Abdominal angiogram following coil embolism of splenic artery.



DISCUSSION

Recurrent upper GI bleed is one of the causes of chronic anemia. The identification of source is essential to reduce catastrophic clinical outcomes. HP is one such potentially life-threatening cause of GI bleed that is challenging to diagnose. Since its first description in literature by Lower and Farrell in 1931, it has been reported approximately 150 times [1]. Currently, the incidence is about one in thousand five hundred cases of GI bleed [2]. HP is essentially a hemorrhage from the pancreatic duct due to rupture of a pseudoaneurysm of arteries coursing around the pancreas, associated with an underlying pancreatic disease process [3]. Splenic artery is most commonly identified as the source of the hemorrhage followed by gastroduodenal, pancreaticoduodenal, hepatic and left gastric arteries in decreasing order of frequency [4,5]. Pseudo aneurysms may rupture into the gastrointestinal tract, peritoneal cavity, pancreatic parenchyma or pancreatic pseudocysts [6]. In our case, the patient was evaluated repeatedly for anemia and was found to have normal endoscopy and colonoscopy findings. His ultrasound abdomen showed evidence of chronic calcifying pancreatitis. Clinical features are usually vague. Patients have a track record of repeated visits to the emergency room for fainting attacks, jaundice and are found to have anemia and elevated levels of amylase and lipase enzymes.

Demonstration of bleeding from the Ampula of Vater during an upper GI endoscopy is sufficient to establish this diagnosis. However, blood clots in the first or second part of the duodenum are still strongly associated with this disease [7]. In our patient, the endoscopy performed under our care documented the presence of clots at the opening of the Ampula. Angiography is the gold standard for locating the source of bleed however; pseudo-aneurysms may also be identified through a contrast-enhanced computed tomography (CECT) scan [8] with an added advantage of establishing whether or not there is a connection with the pancreatic duct. A Doppler study can demonstrate ‘to-and-fro sign' and directional blood flow at the neck of pseudo-aneurysms. HP should be differentiated from rare causes of duodenal bleed such as hemobilia and primary aortoenteric fistula.

Treatment is either medical or surgical intervention to the bleeding artery. The type of treatment largely depends on the hemodynamics of the patient and the previous interventions attempted. Interventional radiology procedures may be embolization of the bleeding artery, balloon tamponade or stent placement. Embolization is more commonly done whereas balloon tamponade and stents are used as a bridge to an elective surgery at a later date. Our patient was a candidate for angio embolization due to his hemodynamic stability.

Surgical treatment is done in the absence of facilities to conduct angiography or to embolise the vessel, when there is hemodynamic instability or recurrent bleeds even after embolization [9]. Surgical treatment may include distal pancreatectomy, splenectomy, central pancreatectomy, intracystic ligation of the blood vessel or aneurysm ligation and bypass graft [10].

Our case report highlights a rare cause of malena in ICU. Timely intervention and appropriate treatment can reduce morbidity and mortality.

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DECLARATION OF INTEREST

None declared.

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