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Case Report

Pancreatic Ascites: A Rare Complication of Necrotizing Pancreatitis

A Case Report and Review of the Literature

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Summary

We describe a young patient with a family history of hereditary pancreatitis who developed extensive pancreatic necrosis complicated by pancreatic ascites. Because of failure of medical management, he was successfully treated with operative necrosectomy and primary wound closure over peripancreatic drains. A postoperative low-output pancreaticocutaneous fistula resolved with time. Pancreatic ascites, as a result of pancreatic duct disruption, is more common in chronic rather than acute pancreatitis and is exceedingly uncommon in the context of necrotizing pancreatitis. When it complicates the latter, treatment should be guided by the principles of management of necrotizing pancreatitis. However, when true pancreatic ascites persists, the pancreatic duct anatomy and site of leak should be defined with endoscopic retrograde pancreatography (ERP). Treatment options include endoscopic duct dilatation and stent placement (if a stricture exists proximal to the leak), onlay pancreaticojejunostomy, or distal pancreatectomy (especially if the leak is located in the distal pancreas or in an enterically isolated distal pancreas).

Key Words: Necrotizing pancreatitis; pancreatic ascites; necrosectomy; pancreatic fistula.

Introduction

Acute necrotizing pancreatitis, which accounts for 3–5% of all patients with acute pancreatitis, represents the most severe form, being responsible for most pancreatitis-associated mortality. In our experience, pancreatic ascites is uncommon, and much more so, in the context of acute necrotizing pancreatitis. In this report, we present a young patient with acute necrotizing pancreatitis complicated by pancreatic ascites who made a full recovery after treatment with operative necrosectomy. Because of the metabolic and potential therapeutic implications of pancreatic ascites, we present this report, as a surprisingly unusual complication of the acute presentation of necrotizing pancreatitis.

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Case Report

A 19-yr-old male farmer developed acute pancreatitis with tachypnea, hypoxemia, pleural effusions, and hyperglycemia. His past medical history was pertinent for a mild transient episode of acute pancreatitis 7 mo prior. He did not use drugs, alcohol, or agents known to cause pancreatitis. Of note was a known