Surgery-Anesthesia2013
OMICS Group Conferences
Accelerating Scientific Discovery
2nd International Conference on
Surgery and Anesthesia
September 16-18, 2013 Las Vegas, USA

Onset of acute pancreatitis with transitor type II in diabetes mellitus: original case report

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Abstract

Objectives: The main objective of this clinical case report was to specify that the acute pancreatitis may start with a onset insulin-necesitant diabetes mellitus-with very high levels of the glycemia (400mg/dl), which later after the hygienic-dietetic, medical and surgical treatment, needed the progressive reduction through reconnaissance of the insulin dosage and later on the insulin interruption, because of the normal glycemia values without insulin.
Materials and Methods: A clinical case of a 42 year old man, a teacher, who came in the Emergency Department presented with a sudden epigastric intense pain, without radiation, accompanied by nausea, vomiting after drinking alcohol. The intestinal transit was present for stools and gases, presented sensibility at the epigastric palpation, without peritoneal irritation signs, and normal rectal touch. The laboratory tests were in normal range except serum amylase=2730u/dL, glycemia=400mg/dl, cholesterol=280mg/dl, triglycerides=320mg/dl, HDL cholesterol=50, LDL cholesterol=40, the urine summary for glucose was positive, urinary amylase=1201. The normal EKG and values of cardiac enzymes has excluded a possible postero-inferior acute myocardial infarction. The abdominal radiography on empty stomach and gastroscopy was normal, and the abodminal ultrasound has shown hepatic steatosis.
Diagnosis: Acute ethanolic pancreatitis, onset of type 2 diabetes mellitus in insulin- dependant, dislipidemia, and hepatic steatosis.
Treatment: After the correct protocol of therapy for acute pancreatitis and equilibration of inaugural diabetes mellitus the patient had stayed with four doses s.c.12UI,10UI,-8UI, and -4UI of rapid Humulin R insulin but the evolution was with accumulation of a liquid collection in medium quantity in the Douglas'pouch, confirmed at the abdominal ultrasound and CT scan. After the emergency laparatomy, the drainage of the liquid that was acumulated in the peritoneal cavity was performed, with the lavage of the peritoneal cavity, but without surgical intervention on the pancreas, because it presented a normal macroscopic aspect, without hemorrhagic or necrosis areas. The post-operative evolution of the patient has been favourable and remain with an conventional insulin scheme in two prises s.c.16UIHN – 12UIHN, which later after repeated controls needed a progressive decreased of the insulin doses to avoid the hypoglicemia and the patient remain without the insulin with normal values of glycemia.
Conclusions:1.It is possible in context of acute pancreatitis to appeared sudden change in the function of the Langerhans β cells which produced insulin and after all complete protocol of therapy was performed everything to become in normal limits.2.This clinical case report releived how complex, impredictible and unexpected changes are possible to appear in acute pancreatitis and how carrefully we must to follow the patient with this dissease because surprises can develop any time.

Biography

She was assistant research of University of Cluj Napoca and now she is consultant internal medicine physician, PhD, assistant professor of University of Oradea, Faculty of Medicine and Pharmacy, Medical Disciplines Department, Romania. Also work at Emergency Hospital Internal Medicine Department and Internal Medicine Office. She has published two books, one monograph and papers in reputed journals. She was invited as a speaker at 9 national and 15 International Conferences. She is Member of Romanian Society of Internal Medicine, Cardiology, Medical Chemistry, Biochemistry and Member of the Balkan Society of Medicine.