Case Pictorial

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Colocutaneous Fistula and Colonic Perforation: An Uncommon Case

Jayabal Pandiaraja[1], Viswanathan Subramaniyam[2]

[1]Post-graduate Student, Department of General Surgery, Government Stanley Medical College & Hospital, Chennai, Tamil Nadu, India, [2]Professor, Department of General Surgery, Government Stanley Medical College & Hospital, Chennai, Tamil Nadu, India.

Colonic complications of severe pancreatitis occur very rarely. Although pancreatic complications such as pancreatic abscess, pseudocyst occurs in many patients, but colonic complications due to pancreatitis were 1%.[1,2] We report an unusual case of colocutaneous fistula and colonic perforation due to acute necrotizing pancreatitis. Pancreatic necroses with colonic complication were rare and early recognition and prompt treatment will reduce mortality.[3]

A 27-year-old male patient who is known alcoholic and smoker for 10 years duration admitted with complaints of abdominal pain for 1-month duration, more on epigastric region, radiating to back associated with history of nausea and vomiting for 10 days duration. Abdominal examination shows mild abdominal distension. On palpation tenderness present more on epigastric and right hypochondrial region. Free fluid was present. On auscultation, bowel sound was sluggish. The patient was diagnosed and treated for acute pancreatitis. During the course of the treatment, the patient developed bleeding per rectum for 4 days duration associated with increased abdominal distension and swelling in the right iliac fossa region for 2 days duration and ruptured on the next day.

Investigation showed anemia with leukocytosis. Mildly elevated liver function test. Renal function test showed hypokalemia. C-reactive protein was positive. Serum amylase and lipase were 896 U/L and 432 U/L, respectively. Contrast enhancing computed tomography Abdomen showed acute pancreatic necrosis with free fluid. Lesser sac collection with air pockets with appears to be communicating with colonic loops (Figures 1a and b). Upper gastrointestinal (GI) endoscopy showed an extrinsic impression on the greater curvature of the stomach and colonoscopy showed colonic perforation in the level of the transverse colon (Figure 2). The patient was diagnosed as acute necrotizing pancreatitis with colocutaneous fistula with colonic perforation. The patient was undergone laparotomy with transperitoneal necrosectomy with

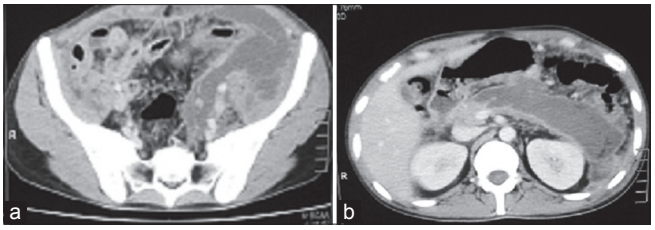

Figure 1: (a and b) Acute pancreatic necrosis with free fluid. Lesser sac collection with air pockets with appears to be communicating with colonic loops

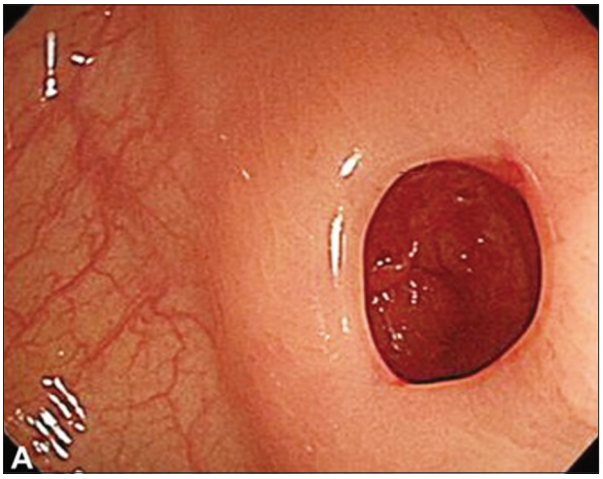

Figure 2: Endoscopic view of perforation at the level of transverse colon

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Corresponding Author: Dr. Jayabal Pandiaraja, Department of General Surgery, Government Stanley Medical College & Hospital, Chennai - 600 001, Tamil Nadu, India. Phone: +91-9629853755. E-mail: dr.pandiaraja@gmail.com

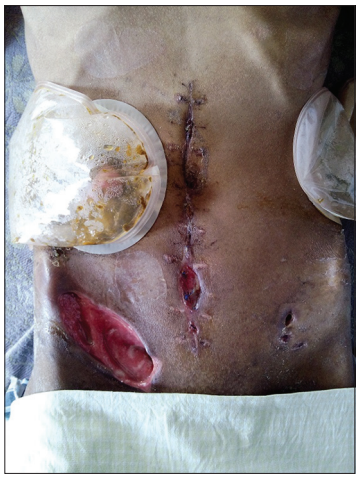

Figure 3: Postoperative status with loop ileostomy with colocutaneous fistula

diversion loop ileostomy. Postoperatively patient recovered well, except mild wound infection (Figure 3).

Points to Ponder

- Infected or necrotizing pancreatitis should be managed surgically as early as possible. This approach improves both morbidity and mortality due to pancreatitis related complications
- Patient were diagnosed as pancreatitis presenting with upper GI or lower GI bleeding symptoms; it is always mandatory to do an upper GI endoscopy or colonoscopy to diagnose perforation or fistula formation due to pancreatitis related complications.

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