CLINICAL IMAGES

Acute haemorrhagic pancreatitis in HIV-positive patients

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Acute pancreatitis in HIV-positive patients is less common than alcohol-related pancreatitis. Haemorrhagic pancreatitis is very rare.

A 23-year-old HIV-positive woman presented with vague upper abdominal pain of 3 days' duration, pain radiating to the back, and vomiting. There was no history of trauma, alcohol use, recent viral illness or drug treatment. She had a tender epigastrium on deep palpation but no rebound, mass or ascites. A chest radiograph was normal and an abdominal radiograph showed dilated loops of small bowel with air in the rectum. Laboratory results were as follows: full blood count: white cell count 10.7×10^9/l (neutrophils 85.5%), haemoglobin concentration 12.9 g/dl, platelet count 146×10^9/l; urea and electrolytes: sodium 130 mmol/l, potassium 3.0 mmol/l, chloride 110 mmol/l, urea 13.9 mmol/l, creatinine 103 µmol/l; liver function tests: all normal; serum amylase 391 U/l. She was admitted for observation and treated symptomatically. Her condition deteriorated, with generalised peritonitis, a very high base excess (–12.5 mmol/l) on arterial blood gas measurement, and a serum amylase level of 341 U/l. An exploratory laparotomy showed free haemorrhagic peritoneal fluid (Fig. 1) (amylase level 3 281 U/l), retroperitoneal blood tracking from the transverse colon to the caecum (Figs 1 and 2), and a grossly inflamed pancreas (Fig. 3). A baseline computed tomography (CT) scan of the abdomen was done on postoperative day 1 (Fig. 4). The CD4 count on postoperative day 3 was 34 cells/µl. The patient improved steadily and was discharged via an antiretroviral (ARV) clinic for follow-up, with no sequelae of acute pancreatitis. A follow-up CT scan of the abdomen on day 20 was normal. What triggered the attack remains obscure.

Dr Arif was a consultant general surgeon at Stanger Regional Hospital, KwaZulu-Natal, at the time of writing. His interests are breast and endocrine surgery and oesophageal and pancreatic cancer.

Dr Nair was a very enthusiastic community medical officer at Stanger Hospital at the time of writing. He passed the FCS 1-A and is now a surgical registrar at the University of KwaZulu-Natal.

Dr Khan is head of surgery at Stanger Hospital and was involved with following up the patient along with Dr Arif. He is particularly interested in upper gastro-intestinal tract surgery.

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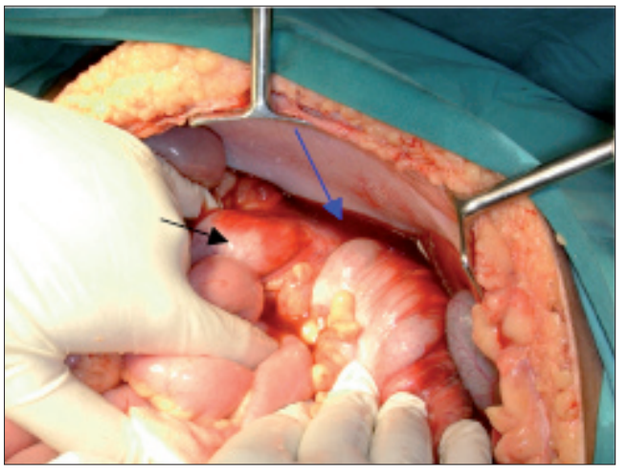

Fig. 1. Blood tracked through the retroperitoneum, including the ascending colon and caecum (black arrow). Free blood in the right paracolic gutter (blue arrow).

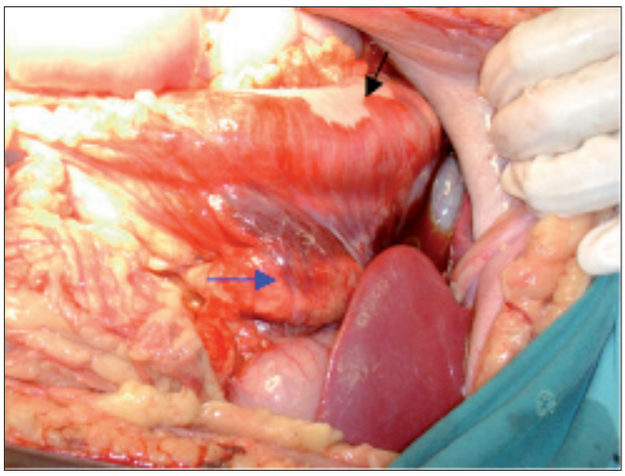

Fig. 2. Transverse colon and blood tracking (black arrow). Grossly inflamed pancreas (blue arrow).

Discussion

We found only one citation on acute haemorrhagic pancreatitis in HIV-positive patients,[1] with 1 of the 2 patients reported to have survived. CT scan facilities would help in the preoperative diagnosis. If the serum and urine amylase remain

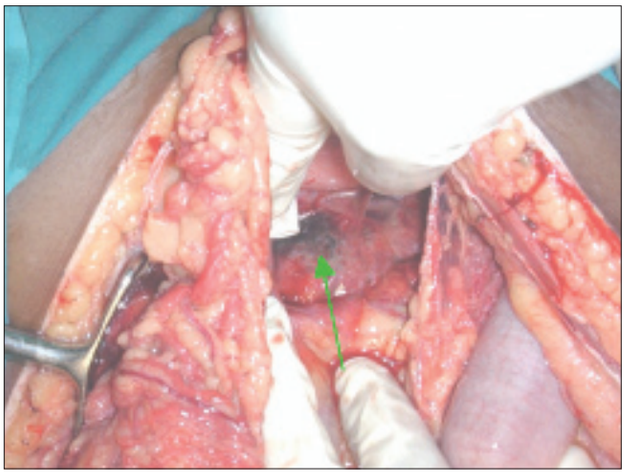

Fig. 3. Inflamed pancreas with patchy necrosis (green arrow).

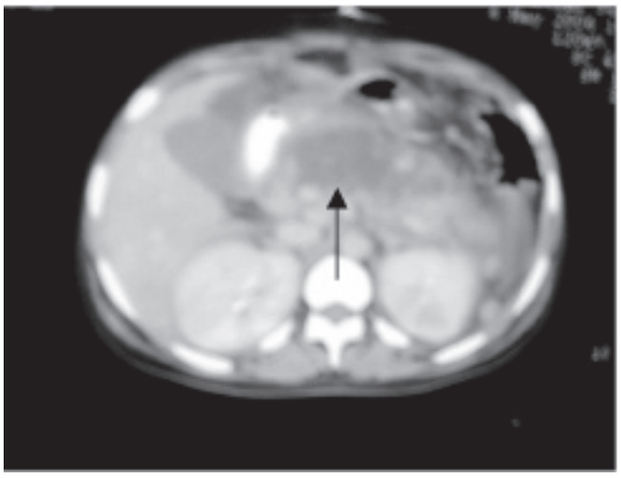

Fig. 4. Grossly oedematous pancreas (black arrow).

normal, diagnosis is difficult. We did not have the facility to measure the serum lipase level, which might have been helpful.

The APACHE II score has been suggested as a more reliable means of monitoring these patients in the ICU setting.[2]

1. Ugwu BT, Obekpa OI. Acute hemorrhagic pancreatitis in HIV positive patients. *West Afr J Med* 2001; 20: 270-271.
2. Greenberger NJ, Toskes PP. Acute and chronic pancreatitis. In: Braunwald E, Fauci AS, Kasper DL, *et al*., eds. *Harrison's Principles of Internal Medicine*. 15th ed. New York: McGraw-Hill, 2001.