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Case Report

Conservative management of symptomatic acute pancreatitis with cholelithiasis in late pregnancy

Vaishali Kondalwar*, Beena Kumari, Priyanka Sureddi, Komal Ahire

Department of Obstetrics and Gynecology, Dr. Babasaheb Ambedkar Memorial Hospital, Central Railway, Byculla, Mumbai, Maharashtra, India

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***Correspondence:**

Dr. Vaishali Kondalwar,

E-mail: kondalwarvaishali712@gmail.com

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ABSTRACT

Acute biliary pancreatitis in pregnancy is rare and poses significant maternal-fetal risks. This paper presents a 26-year-old primigravida at 32+2 weeks gestation presented with epigastric pain and bilious vomiting. Diagnosis confirmed via elevated pancreatic enzymes and ultrasonography showing cholelithiasis. A Conservative management followed with bowel rest and intravenous fluids; the patient remained stable and later delivered a healthy infant at term. This paper also brings forward how early recognition and a multidisciplinary approach allow for successful non-operative management and favorable outcomes.

Keywords: Acute pancreatitis, Cholelithiasis, Conservative management, Third trimester pregnancy

INTRODUCTION

Acute pancreatitis in pregnancy is an uncommon clinical condition with an incidence ranging from 1 in 1,000 to 1 in 10,000 pregnancies.¹ It most commonly encountered during the third trimester and is frequently associated with gallstone disease and less commonly, hypertriglyceridemia. Hormonal changes during pregnancy particularly increased progesterone levels contribute to gallbladder hypomotility and bile stasis predisposing to gallstone formation.³⁻⁵ The clinical presentation may overlap with other gastrointestinal conditions encountered during pregnancy, which can delay diagnosis. Prompt identification and appropriate management are essential to reduce maternal and fetal morbidity. While mild cases are usually managed conservatively, severe cases may require interventional or surgical management. We present a case of acute pancreatitis associated with cholelithiasis in late pregnancy that was successfully managed without surgical intervention.

CASE REPORT

A 26-year-old, female, primigravida with spontaneous conception at 33+2 weeks of gestation presented to the emergency department with severe epigastric pain of sudden onset, pain was continuous, radiating to the back, worsening after meals. It was associated with multiple episodes of bilious vomiting (8-9 episodes per day) with no relieving factors. She also reported of generalized weakness for past four days. Perception of fetal movement present. No history suggestive of peptic ulcer disease, gastroesophageal reflux disease, cholangitis, pregnancy induced hypertension. Additionally, she had no history of abdominal trauma, drug intake like (steroids, thiazides, valproate, azathioprine, NSAIDS) causing pancreatitis. No history of hypercalcemia, childhood viral infections (mumps, hepatitis), no history of smoking, alcoholism and substance abuse. She was a registered case and on regular antenatal care follow up.

Patient was admitted in maternity ward for further evaluation and management.

Examination

On examination, her vital signs were stable. Per abdominal examination revealed epigastric tenderness without guarding or rigidity. Obstetric examination showed a uterus corresponding to 34 weeks of gestation, relaxed, with a longitudinal lie and cephalic presentation. The fetal heart rate was 135 bpm, and the nonstress test was reactive. Ultrasound of the abdomen and pelvis dated 11/07/25 showed a distended gallbladder, bulky pancreatic neck and proximal body, minimal ascites, and mild hydroureteronephrosis secondary to the gravid uterus.

Laboratory tests revealed elevated serum amylase (719 U/l), Serum lipase (1017 U/l), leukocytosis (12800/mm), elevated CRP (42.4 mg/l).



Figure 1: Echogenic intraluminal foci in gallbladder with posterior acoustic shadow S/O cholelithiasis.

Final diagnosis

A 26-year-old, female, primigravida with spontaneous conception at 33+2 weeks of gestation with acute pancreatitis secondary to cholelithiasis in late pregnancy.

The patient was admitted and valid, informed, written high risk consent was taken. Urgent surgical reference sought. Patient was managed conservatively in collaboration with obstetrician and surgeon. Patient was kept nil per oral (NPO) to rest pancreas and Ryle's tube inserted with continuous aspiration to allow for bowel rest. Intravenous fluids (ringer lactate preferred), electrolyte correction, strict input- output charting and intravenous antibiotics with symptomatic treatment. Daily fetal heart rate monitoring was done. Serial monitoring of biochemical tests done. The patient showed gradual clinical improvement, with a decline in pancreatic enzyme levels over the subsequent days. Ryle's tube removed after 5 days. Patient gradually shifted to oral diet with sips of water, followed by full oral low-fat diet. Maternal vitals

and laboratory parameters were monitored closely. Enzyme levels gradually normalized.

Close multidisciplinary antenatal surveillance was maintained through joint consultation between the surgeon and obstetrics services for maternal stabilization while continuing pregnancy. No surgical and endoscopic intervention was required during the antenatal period as the patient responded well to conservative management.

The pregnancy was continued under close maternal and fetal surveillance. At 38+4 weeks of gestation, the patient went into spontaneous labor and delivered a healthy infant weighing 2.82 kgs via normal vaginal delivery. Both maternal and neonatal outcomes were favorable, and no postpartum complications were observed.

DISCUSSION

Acute pancreatitis in pregnant women is a challenge for both obstetricians and gastroenterologists. Acute pancreatitis can be potentially life-threatening to both mother and fetus. Therefore, risk factors such as gallstones and hypertriglyceridemia should be diagnosed early in pregnancy, which can be achieved with simple tests.¹⁻⁴ In the present case, cholelithiasis was identified as the underlying etiology, consistent with literature reporting gallstones as the most frequent cause of pancreatitis during pregnancy accounting for nearly 70% of cases.^{5,6} Pregnancy-related hormonal changes increase cholesterol saturation and decrease gallbladder motility predisposing to stone formation. Serum amylase and lipase levels are reliable diagnostic markers and ultrasonography is the preferred imaging modality during pregnancy.⁷

Conservative management is first line approach in mild cases- including fluid resuscitation, bowel rest, pain control, nutritional support.^{8,9}

While surgical intervention is reserved for severe or recurrent pancreatitis. Interventional procedures such as Endoscopic retrograde cholangiopancreatography (ERCP) may be indicated in cases complicated by progressive obstructive jaundice, cholangitis, failure of conservative management. ERCP can be safely performed in all trimesters using radiation-minimizing or radiation-free techniques with appropriate fetal shielding.¹⁰

Cholecystectomy is indicated in cases of recurrent biliary pancreatitis, recurrent biliary colic, gallstone-related complications not responding to conservative management. The second trimester is considered the safest period for surgical intervention. Open cholecystectomy approach is avoided whenever possible because of its higher morbidity. Open surgical necrosectomy is considered only as a last resort in patients with persistent sepsis or clinical deterioration despite less invasive intervention.¹⁰⁻¹²

Delivery is not routinely indicated for acute pancreatitis. Unless in cases of severe pancreatitis with progressive maternal deterioration, multiorgan failure, or non-reassuring fetal status. In this case, continuation of pregnancy under close monitoring resulted in favorable outcome.

CONCLUSION

Acute pancreatitis though rare in pregnancy, must be considered in women presenting with upper abdominal pain, particularly in the third trimester. Early diagnosis using biochemical and imaging modalities, coupled with prompt multidisciplinary management involving obstetric and surgeon team is key to significantly improve maternal and fetal prognosis.^{11,12} Conservative management is safe and effective in mild cases allows continuation of pregnancy to term in most of patients. Operative intervention in acute pancreatitis with cholelithiasis during pregnancy is reserved for clearly defined indications and is guided by disease severity, gestational age and maternal-fetal status. Delivery decision should be individualized and based primarily on obstetric indications.

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