FACULTAD DE CIENCIAS DE LA SALUD

PROGRAMA DE MEDICINA INTERNA

EVALUACIÓN DE LA PANCREATITIS AGUDA EN EL SERVICIO DE HOSPITALIZACIÓN DE UNA IPS EN LA CIUDAD DE BARRANQUILLA (ATL, CO). EN LOS AÑOS 2019 Y 2020.

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RESUMEN

La pancreatitis aguda es una de las principales causas que constituyen una variable morbimortalidad a nivel mundial. Debido a su severidad es importante determinar por medio de la clínica, estudios de laboratorio e imagenológicos, su etiología.

Son muchas las causas de pancreatitis aguda, siendo la primera causa los cálculos biliares debido a que los cálculos obstruyen el conducto pancreático, seguido del consumo prolongado de alcohol, más frecuente en el sexo masculino, por diferencias en la ingesta y factores genéticos y como tercera causa la hipertrigliceridemia. Otras causas menos frecuentes son el tabaquismo, la hipercalcemia, enfermedades autoinmunes, la exposición a fármacos, la obesidad y la pancreatitis idiopática que puede estar relacionada con toxinas ambientales y polimorfismos genéticos.

Para el diagnóstico de pancreatitis aguda el paciente debe cumplir con al menos 2 de los siguientes 3 criterios: dolor en hemiabdomen superior, generalmente irradiado a espalda; niveles de amilasa y/o lipasa séricos superior a 3 veces el límite de lo normal y hallazgos típicos de pancreatitis aguda por estudios imagenológicos de abdomen.

Objetivo: Evaluar la pancreatitis aguda de acuerdo a su etiología en los años 2019 y 2020 en una clínica de cuarto nivel.

Materiales y métodos: se realizó un estudio descriptivo de estudio poblacional, retrospectivo, transversal. Se tomo como población a estudiar pacientes masculinos y femeninos mayores de 18 años en el servicio de hospitalización con diagnóstico de pancreatitis aguda en los años 2019 y 2020. La información recopilada fue sistematizada por medio de Excel y del programa STATGRAPHICS Centurión Versión XVI.

Resultados: 61 pacientes cumplieron criterios de pancreatitis aguda, basado en datos del último consenso de Atlanta con edad promedio de 49 años y mayor incidencia de pancreatitis en mujeres (63,9%). Se encontró que en promedio los pacientes del estudio padecen de 3,7 ± 1,5 comorbilidades. Además, que no existe evidencia de diferencia estadísticamente significativa entre la frecuencia de las comorbilidades en ambos géneros. Los hallazgos típicos de imágenes fueron

mayores en el género masculino que en el femenino. Encontramos que 60/61 de los pacientes (98,36 %) padecen de dolor abdominal, seguido del aumento de la amilasa (68,85 %) y lipasa (67,21 %).

Conclusión: La pancreatitis aguda puede variar en cuanto su grado de severidad, teniendo así desde una presentación leve a una condición grave. El diagnóstico está basado en 3 pilares fundamentales; dolor abdominal localizado en epigastrio/mesogastrio, incremento de lipasa y/o amilasa > 3 veces su valor normal, y hallazgos imagenológicos. Con 2/3 de estos criterios podemos establecer el diagnóstico de pancreatitis aguda.

En cuanto al tratamiento, inicialmente se debe manejar con líquidos endovenosos, suplementación nutricional en donde la vía oral este contraindicada y las complicaciones y su resolución irán ligadas al desencadenante de la pancreatitis aguda, por ejemplo, si es generada por cálculos biliares deberá realizarse colecistectomía previo a su egreso y el resto de complicaciones deberán ser evaluadas con el equipo médico interdisciplinar los cuales pueden incluirse, desde internistas, cirujano hepatobiliar, gastroenterólogos y radiólogos intervencionistas.

Palabras clave: pancreatitis aguda, calculo biliar, abuso de alcohol, hipertrigliceridemia, comorbilidades.

ABSTRACT

Speaking of acute pancreatitis we must make clear the main causes that constitute a morbidity and mortality variable worldwide. Due to its severity, it is important to determine its etiology through clinical, laboratory and imaging studies.

There are many causes of acute pancreatitis, the first cause being gallstones because the stones obstruct the pancreatic duct, followed by prolonged alcohol consumption, more frequent in males, due to differences in intake and genetic factors, and third causes hypertriglyceridemia. Other less common causes include smoking, hypercalcaemia, autoimmune diseases, drug exposure, obesity, and idiopathic pancreatitis, which may be related to environmental toxins and genetic polymorphisms.

For the diagnosis of acute pancreatitis, the patient must meet at least 2 of the following 3 criteria: pain in the upper abdomen, generally radiating to the back; serum amylase and/or lipase levels greater than 3 times the normal limit and typical findings of acute pancreatitis on abdominal imaging studies.

Objective: To evaluate acute pancreatitis according to its etiology in the years 2019 and 2020 in a fourth level clinic.

Materials and methods: a descriptive, retrospective, cross-sectional, population-based study was carried out. Male and female patients over 18 years of age in the hospitalization service diagnosed with acute pancreatitis in the years 2019 and 2020 were taken as the population to study. The information collected was systematized through Excel and the program STATGRAPHICS Centurion Version XVI.

Results:61 patients met the criteria for acute pancreatitis, based on data from the latest Atlanta consensus, with a mean age of 49 years and a higher incidence of pancreatitis in women (63.9%). It was found that on average the patients in the study suffer from 3.7 ± 1.5 comorbidities. additionyes, that there is no evidence of a statistically significant difference between the frequency of comorbidities in both genders. LTypical imaging findings weregreater in the masculine gender than in the feminine. We found that 60/61 of the patients (98.36%) suffer from abdominal pain, followed by increased amylase (68.85%) and lipase (67.21%).

Conclusion: Acute pancreatitis can vary in its degree of severity, thus ranging from a mild presentation to a serious condition. The diagnosis is based on 3 fundamental pillars; abdominal pain located in the epigastrium/mesogastrium, increased lipase and/or amylase > 3 times its normal value, and imaging findings. With 2/3 of these criteria we can establish the diagnosis of acute pancreatitis.

Regarding treatment, initially it should be managed with intravenous fluids, nutritional supplementation where the oral route is contraindicated and the complications and their resolution will be linked to the trigger of acute pancreatitis, for example, if it is caused by gallstones, prior cholecystectomy should be performed. upon discharge and the rest of the complications should be evaluated with the interdisciplinary medical team, which may include internists, hepatobiliary surgeons, gastroenterologists, and interventional radiologists.

Keywords: acute pancreatitis, gallstones, alcohol abuse, hypertriglyceridemia, comorbidities.

Referencias Bibliográficas

1. Johnson CD, Besselink MG, Carter R. Acute pancreatitis. BMJ [Internet]. 2014 Aug 12;349(aug12 4):g4859–g4859. Available from: https://www.bmj.com/lookup/doi/10.1136/bmj.g4859
2. Johnstone C. Pathophysiology and nursing management of acute pancreatitis. Nursing Standard. 2018 Jun;33(4):75–82.
3. Zhong F ping, Wang K, Tan X qin, Nie J, Huang W feng, Wang X fang. The optimal timing of laparoscopic cholecystectomy in patients with mild gallstone pancreatitis. Medicine. 2019 Oct;98(40):e17429.
4. Coté GA, Yadav D, Slivka A, Hawes RH, Anderson MA, Burton FR, et al. Alcohol and Smoking as Risk Factors in an Epidemiology Study of Patients With Chronic Pancreatitis. Clinical Gastroenterology and Hepatology. 2011 Mar;9(3):266–73.
5. Apte M v, Pirola RC, Wilson JS. Mechanisms of alcoholic pancreatitis. J Gastroenterol Hepatol. 2010 Dec;25(12):1816–26.
6. Phillip V, Huber W, Hagemes F, Lorenz S, Matheis U, Preinfalk S, et al. Incidence of Acute Pancreatitis Does Not Increase During Oktoberfest, but Is Higher Than Previously Described in Germany. Clinical Gastroenterology and Hepatology. 2011 Nov;9(11):995-1000.e3.
7. Pretis N, Amodio A, Frulloni L. Hypertriglyceridemic pancreatitis: Epidemiology, pathophysiology and clinical management. United European Gastroenterol J. 2018 Jun;6(5):649–55.
8. Roberts SE, Morrison-Rees S, John A, Williams JG, Brown TH, Samuel DG. The incidence and aetiology of acute pancreatitis across Europe. Pancreatology. 2017 Mar;17(2):155–65.
9. Yadav D, Lowenfels AB. The Epidemiology of Pancreatitis and Pancreatic Cancer. Gastroenterology. 2013 May;144(6):1252–61.
10. Setiawan VW, Pandol SJ, Porcel J, Wei PC, Wilkens LR, le Marchand L, et al. Dietary Factors Reduce Risk of Acute Pancreatitis in a Large Multiethnic Cohort. Clinical Gastroenterology and Hepatology. 2017 Feb;15(2):257-265.e3.

11. Barkin JA, Nemeth Z, Saluja AK, Barkin JS. Cannabis-Induced Acute Pancreatitis. Pancreas. 2017 Sep;46(8):1035–8.
12. Sadr-Azodi O, Andrén-Sandberg Å, Orsini N, Wolk A. Cigarette smoking, smoking cessation and acute pancreatitis: a prospective population-based study. Gut. 2012 Feb;61(2):262–7.
13. Majumder S, Gierisch JM, Bastian LA. The Association of Smoking and Acute Pancreatitis. Pancreas. 2015 May;44(4):540–6.
14. Kume K, Masamune A, Ariga H, Shimosegawa T. Alcohol Consumption and the Risk for Developing Pancreatitis. Pancreas. 2015 Jan;44(1):53–8.
15. Sadr-Azodi O, Orsini N, Andrén-Sandberg Å, Wolk A. Abdominal and Total Adiposity and The Risk of Acute Pancreatitis: A Population-Based Prospective Cohort Study. American Journal of Gastroenterology. 2013 Jan;108(1):133–9.
16. Hong S, Qiwen B, Ying J, Wei A, Chaoyang T. Body mass index and the risk and prognosis of acute pancreatitis. Eur J Gastroenterol Hepatol. 2011 Nov;23(12):1136–43.
17. Girman CJ, Kou TD, Cai B, Alexander CM, O'Neill EA, Williams-Herman DE, et al. Patients with type 2 diabetes mellitus have higher risk for acute pancreatitis compared with those without diabetes. Diabetes Obes Metab. 2010 Apr 12;12(9):766–71.
18. SORENSEN HT, JACOBSEN J, NORGAARD M, PEDERSEN L, JOHNSEN SP, BARON JA. Newer cyclo-oxygenase-2 selective inhibitors, other non-steroidal anti-inflammatory drugs and the risk of acute pancreatitis. Aliment Pharmacol Ther. 2006 Jul;24(1):111–6.
19. Vinklerová I, Procházka M, Procházka V, Urbánek K. Incidence, Severity, and Etiology of Drug-Induced Acute Pancreatitis. Dig Dis Sci. 2010 Oct 25;55(10):2977–81.
20. Sadr–Azodi O, Sanders DS, Murray JA, Ludvigsson JF. Patients With Celiac Disease Have an Increased Risk for Pancreatitis. Clinical Gastroenterology and Hepatology. 2012 Oct;10(10):1136-1142.e3.

21. Senosiain Lalastra C, Tavío Hernández E, Moreira Vicente V, Maroto Castellanos M, García Sánchez MC, Aicart Ramos M, et al. Pancreatitis aguda por hipertrigliceridemia. Gastroenterol Hepatol. 2013 Apr;36(4):274–9.
22. Banks PA, Bollen TL, Dervenis C, Gooszen HG, Johnson CD, Sarr MG, et al. Classification of acute pancreatitis—2012: revision of the Atlanta classification and definitions by international consensus. Gut. 2013 Jan;62(1):102–11.
23. Sarri G, Guo Y, Iheanacho I, Puelles J. Moderately severe and severe acute pancreatitis : a systematic review of the outcomes in the USA and European Union-5. BMJ Open Gastroenterol. 2019 Feb 16;6(1):e000248.
24. Greenberg JA, Hsu J, Bawazeer M, Marshall J, Friedrich JO, Nathens A, et al. Clinical practice guideline: management of acute pancreatitis. Canadian Journal of Surgery. 2016 Apr 1;59(2):128–40.
25. James TW, Crockett SD. Management of acute pancreatitis in the first 72 hours. Curr Opin Gastroenterol. 2018 Sep;34(5):330–5.
26. García-Rayado G, Cárdenas-Jaén K, Madaria E. Towards evidence-based and personalised care of acute pancreatitis. United European Gastroenterol J. 2020 May;8(4):403–9.
27. Leppäniemi A, Tolonen M, Tarasconi A, Segovia-Lohse H, Gamberini E, Kirkpatrick AW, et al. 2019 WSES guidelines for the management of severe acute pancreatitis. World Journal of Emergency Surgery. 2019 Dec 13;14(1):27.
28. Walkowska J, Zielinska N, Tubbs RS, Podgórski M, Dłubek-Ruxer J, Olewnik Ł. Diagnosis and Treatment of Acute Pancreatitis. Diagnostics. 2022 Aug 15;12(8):1974.
29. Wang J, Liu Q xie, Teng D ling, Ding Y bing, Lu G tao, Gong W juan, et al. Elevated serum ferritin levels are associated with severity and prognosis of severe acute pancreatitis: a preliminary cohort study. BMC Gastroenterol. 2022 Sep 5;22(1):408.
30. Chatila AT, Bilal M, Guturu P. Evaluation and management of acute pancreatitis. World J Clin
31. Ingraham NE, King S, Proper J, Siegel L, Zolfaghari EJ, Murray TA, et al. Morbidity and Mortality Trends of Pancreatitis: An Observational Study. Surgical Infections 2021;22:1021–30. https://doi.org/10.1089/sur.2020.473

32. Lohse MR, Ullah K, Seda J, Thode HC, Singer AJ, Morley EJ. The role of emergency department computed tomography in early acute pancreatitis. The American Journal of Emergency Medicine 2021;48:92–5. https://doi.org/10.1016/j.ajem.2021.04.026.
33. Berger Z, Mancilla C, Tobar E, Morales MP, Baró M, Carrasco M, et al. Acute pancreatitis in Chile: A multicenter study on epidemiology, etiology and clinical outcome. Retrospective analysis of clinical files. Pancreatology 2020;20:637–43. https://doi.org/10.1016/j.pan.2020.04.016.
34. Adiamah A, Kushairi A, Tumilty S, Na Y, Crook M, Brooks AJ, et al. Hypertriglyceridaemia as a risk factor for critical care admission in acute pancreatitis: A prospective study. Clinical Nutrition ESPEN 2020;39:227–3