

Title:
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Acute necrotising pancreatitis secondary to a pancreatic foreign body

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Dear Editor,

98% of ingested foreign bodies pass through the digestive tract without complications. Only 1% result in complications, with the most frequent involved being sharp objects, such as fish bones (1). One of the potential complications is mucosal perforation, which can reach solid organs such as the liver or pancreas in up to 1% of cases. Associated complications are potentially serious, including pancreatitis, pancreatic abscess and pseudoaneurysm (2).

CLINICAL CASE

We present the case of a 68-year-old woman who attended the emergency department for epigastralgia radiating to the back after eating hake. Laboratory tests showed elevated amylase (2600 mg/ml) and marked elevation of acute phase reactants. Given the clinical and analytical worsening during evolution, an abdominal CT scan was performed with the finding of a radio-opaque foreign body at the pre-pyloric level, suggestive of a fishbone, which perforated the gastric wall until reaching the neck of the pancreas, causing oedematization and the presence of free fluid at this level, in the context of acute oedematous pancreatitis (Figure 1A-B).

Given its location and length, as well as the extent to a solid organ, which made endoscopic removal unfeasible, laparotomy was performed and a 4 cm fishbone was found embedded in the neck of the pancreas with an extensive associated haematoma, which was removed. The patient initially evolved in a torpid manner with an imaging test finding of extensive necrotising pancreatitis with necrotising collections with a good response to enteral nutrition and antibiotic therapy. Finally, the patient evolved favourably and was discharged home with complete recovery.

The diagnosis of penetrating foreign bodies is a diagnostic challenge, since it is an infrequent complication, most patients do not recall any history of recent ingestion, they are asymptomatic until a complication appears, the symptoms may simulate epigastric pain of any other aetiology and there are currently no standardised tools available for their optimal management (3). Computed tomography is established as the fundamental diagnostic test for the diagnosis and localisation of the foreign body, as well as the presence of complications associated with it (4). Surgical treatment by laparoscopy is considered a safe and effective procedure, with lower complication rates and hospital stay. The trend in foreign body management is towards minimally invasive treatment, with endoscopic management gradually gaining prominence (5).

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Figure 1. Axial (A) and sagittal (B) sections of the abdomen showing a 4 cm sharp hyperdense foreign body at the level of the pyloric antrum crossing the wall and contacting the pancreatic.