Abstract

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Acute Pancreatitis and Fournier's Gangrene: A Case Report

Vitelli N*, Vitale A, Cardamone A, Bottiglieri M, Palmisano L, Landi M, Iacono O, Tirelli P, Coppola MG, Madonna P, Lugara M, Bologna C.

Internal Medicine Unit, Ospedale Del Mare, Naples, Italy

Abstract

Fournier's Gangrene is a rare form of necrotizing fasciitis (NF) that involves perineal region and external genitalia. It is frequently a polymicrobial infection with a high rate of mortality ranging from 20 to 40%. FG affects mainly men over 50 years of age, with a male to female ratio of 10:1. Risk factors includes: diabetes, alcohol abuse, immunodeficiency, malignancy, use of cytotoxic drugs and steroids. Therapy is based on fluid resuscitation and large spectrum antibiotics, effective against gram negative, gram positive and anaerobic bacteria. Surgical debridement and VAC therapy are useful in source control. Many patients can require surgical reconstruction after recovery. A 55 years old patient came to our attention in the emergency department with septic shock. He reported history of episodes of abdominal pain, not currently present, alcohol abuse and type 2 diabetes mellitus. He did not report noticeable current symptoms. Patient presented body temperature of 38°C, blood pressure of 80/60mmHg, respiratory failure and anuria. Blood tests showed a severe thrombocytopenia with 13000 platelet/mm^3, leukocytosis with neutrophilia, renal failure and elevation of C-reactive protein and procalcitonin. Patient also presented mild elevation of lipase and amylase. Patient started fluid and inotropic support therapy and large spectrum antibiotic therapy with piperacillin-tazobactam. Blood cultures were settled and, as soon as result was available, they showed an Escherichia Coli, Klebsiella Pneumonia and Streptococcus Anginosus infection. Antibiotic therapy was modified according with the antibiograms with Tigecycline, meropenem and with the addition of Caspofungin. When clinical conditions were slightly improving, patient referred mild pain of new onset in perineal region and the presence of purulent exudate in this region. At the clinical examination it was evidenced a fistula, whose presence was never noticed by the patient. The fistula was surgically treated, and cultures of exudate were performed. They showed presence of Morganella Morgan, Enterococcus Durans and Candida Albicans. These germs were found sensitive to the on-going antibiotic therapy. A contrast enhanced CT was performed, and it showed multiple pancreatic, per pancreatic and abdominal abscesses, sign of chronic pancreatitis and portal vein thrombosis. In perineal region CT showed acute necrotizing fasciitis, extended to scrotal and intergluteal region. Patient critical clinical condition and the extension of septic abdominal process made patient non eligible for any surgical intervention. Exitus was caused by an acute and massive upper digestive tract bleeding, facilitated by severe thrombocytopenia that worsened the patient already precarious conditions. CT scan evidences and patient medical history suggest that chronic alcohol abuse lead to development of chronic pancreatitis, testified also by chronic abdominal pain history. It's reasonable that a new episode of acute on chronic pancreatitis or the infection of a preexisting pseudo cysts, led to a disseminated abdominal septic process and finally, through the retro peritoneum, to the extension of this process to the perineum. In our knowledge, only 2 other cases of FG and NF AP-related were described. We suggest that AP could be considered while researching of potential source of infection in FG.