



A bizarre presentation of pancreatitis with Bryant's sign

To the Editor,

Most patients with acute pancreatitis recover uneventfully with appropriate medical management. However, life-threatening complications develop in 20-25% of cases, and various early surgical measures have been proposed for treating these patients (1).

A 57-year-old man was admitted because of abdominal pain and vomiting; he had a history of right inguinal hernia and type 1 diabetes mellitus. Physical examination revealed mild abdominal distention, no incision scar, abdominal tenderness, minimal bowel sounds, a tender and bruised scrotum, and an irreducible hernia. Abdominal radiography revealed abnormal small intestinal air fluid levels, and ultrasonography revealed fluid in the hernia and abdomen. Emergency surgery for the strangulated inguinal hernia was initiated, and opening of the hernia sac revealed intestinal segments with bloody, gray fluid. A midline incision subsequently revealed necrotizing, hemorrhagic pancreatitis with cholelithiasis. Cholecystectomy and necrosectomy were performed, and multiple abdominal drainage catheters were placed. Somatostatin analogue (SSA) was started afterward for fistula control. However, we observed that jejunal fluid oozed from the drainage catheters, despite administration of SSA. At the sites of the midline, inguinal, and scrotal incisions, we also observed multiple fistulas oozing pancreatic fluid (Figure 1). Endoscopic retrograde cholangiopancreatography (ERCP) revealed bile leakage from the cystic stump; therefore, a plastic stent was inserted into the ductus choledochus. Twenty days after the operation, ileum fluid was still observed, and subsequent reoperation revealed perforation of the ileum at the ileocecal junction. Per-operative surgeon performed ERCP do not revealed any bile leakage, and plastic stent placement and maturation of the loop ileostomy appeared appropriate. Unfortunately,

biliary fluid leakage persisted, and a third ERCP was performed, during which leakage from the cystic stump was still noted. A nasobiliary drainage catheter was inserted, and the fistula subsequently resolved. At the 45th day after admission, the patient was discharged well and was recommended outpatient monitoring. He was well after 6 months of discharge.

This case may be the first reported case of hemorrhagic pancreatitis in a patient presenting with bluish discoloration at the right side of the scrotum; this case is similar to John Henry Bryant's report on hemorrhage into the retroperitoneum causing discoloration of the scrotal epithelium. Although SSAs have been a necessary component of gastrointestinal fistula treatment, some trials have failed to demonstrate its therapeutic benefit. Çoker A et al. (2) have demonstrated in a rat model of pancreatitis that high level of a platelet-activating factor



Figure 1. Pancreatic fluid oozing from fistulas at scrotal and right inguinal incisions, with discoloration of the scrotal epithelium (Bryant's sign).

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is reduced with SSA treatment. They speculated that SSAs does not reduce pancreatic enzyme production, but prevents their excretion, thereby aggravating autodigestion and the clinical condition. In conclusion, we believe that pancreatitis should be considered in all patients with abdominal pain.

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