

The Editors welcome topical correspondence from readers relating to articles published in the *Journal*. Letters should be submitted electronically via the BJS submission site (mc.manuscriptcentral.com/bjs). All correspondence will be reviewed and, if approved, appear in the *Journal*. Correspondence must be no more than 300 words in length.

Acute pancreatitis in a COVID-19 patient

Editor

We read with interest Spinelli and Pellino's Leading Article¹, highlighting their experience of COVID-19, a global pandemic that is rapidly changing and challenging the scope of surgical practice². Recent intercollegiate guidance has recommended a drastic change of approach in the management of surgical patients, including the suspension of all but emergency operations³. We highlight a case of acute pancreatitis in a patient with recently diagnosed COVID-19.

A 59-year-old female patient, with a history of cholecystectomy and thrombophilia, initially presented to the emergency department with fever, cough, sore throat and myalgia having recently returned from a cruise in the Caribbean. Polymerase Chain Reaction confirmed COVID-19 and she was treated with simple supportive measures. She was commenced on intra-

venous vancomycin for a streptococcal pneumonia complicating COVID-19 infection, and discharged on day 5 with a course of doxycycline.

Five days following discharge, she was readmitted with fever, abdominal pain and constipation, and treated for presumed adhesional bowel obstruction. Laboratory investigations demonstrated a white cell count of $14.3 \times 10^9/l$, C-reactive protein of 62.7 g/l, international normalized ratio (INR) of 5.2, and normal liver function. Unfortunately, no amylase was done on admission. As symptoms were not improving with conservative management, a CT was obtained on day 3. This demonstrated a previously atrophic pancreas that had increased markedly in size and had features of diffuse oedematous changes, suspicious for acute pancreatitis. The patient was managed conservatively and discharged after 7 days.

The aetiology of pancreatitis in this case is idiopathic given the history of cholecystectomy, minimal alcohol use and lack of precipitating risk factors. Up to 10 per cent of acute pancreatitis is thought to have an infectious aetiology through an immune-mediated inflammatory response, most notably mumps and Coxsackie B viruses⁴. The recent positive COVID-19 diagnosis and reports of gastrointestinal symptoms in this disease raise the suspicion that there may be an association between this novel virus and acute pancreatitis.

E. R. Anand^{ORCID}, C. Major, O. Pickering and M. Nelson
Department of General Surgery, St Mary's Hospital, Isle of Wight NHS Trust, Newport, UK

DOI: 10.1002/bjs.11657

- 1 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020. <https://doi.org/10.1002/bjs.11627> [Epub ahead of print].
- 2 World Health Organization. *Rolling updates on coronavirus disease (COVID-19)*; 2020. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen> [accessed 3 April 2020].
- 3 Royal College of Surgeons of England. *Updated Intercollegiate General Surgery Guidance on COVID-19*; 2020. https://www.rcseng.ac.uk/coronavirus/joint-guidance-for-surgeons-v2/?utm_campaign=1358042_Coronavirus%20comms%2026%2F03%20to%20members&utm_medium=dotmailer&utm_source=emailmarketing&dm_i=4D4N,T3VE,37HX66,3I9U4,1 [accessed 3 April 2020].
- 4 Rawla P, Bandaru SS, Vellipuram AR. Review of infectious etiology of acute pancreatitis. *Gastroenterology Res* 2017; **10**: 153–158.