Case Report

Pseudocyst Pancreas with Delirium in a Married Alcohol Dependent Male: A Rare Presentation

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ABSTRACT

We herein present a patient with a history of heavy alcohol abuse who developed pseudocyst Pancreas and delirium, who came to our hospital for treatment. The patient recovered well with treatment.

Key words: *Alcohol dependence, delirium, pseudocyst pancreas*

INTRODUCTION

Pancreatic pseudocysts have been recognized for over 185 years[1] and may arise in association with acute or chronic pancreatitis, pancreatic trauma, or pancreatic duct obstruction. Today clinically, most cases are alcohol-related disorders, and more than half are thought to resolve spontaneously.[2] Pseudocysts usually develop in patients with alcoholic pancreatitis. In countries where alcohol consumption is high, pseudocysts develop in 59–78% of patients along with alcoholic pancreatitis.[3] Pancreatic pseudocysts can be asymptomatic; however, they can often be manifested by persistent abdominal pain, anorexia, nausea and vomiting. Basic diagnostic procedures which allow visualization of a pseudocyst are ultrasonographic abdomen examination and computed tomography (CT). Herein, we present a patient with a history of heavy alcohol abuse, who came to our hospital for treatment.

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CASE REPORT

A 33-year-old male, married patient from a rural background presented in the emergency unit of our hospital with a history of alcohol dependence from the past 10 years. The patient presented with a history of recurrent episodes of abdominal pain, tenderness in epigastric region, and weight loss from the past 6 years. The patient had an episode of alcohol withdrawal seizure 2 months back. His multiple clinical problems were manifestations of chronic pancreatitis and its complications which included raised blood sugar levels. His pancreatitis was initially precipitated by heavy alcohol use. The patient used to take heavy alcohol every day for the past 10 years. He was irritable and

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aggressive in nature. He used to have recurrent fights with his family members after taking alcohol. His vital signs at initial presentation in the emergency unit were clinically afebrile, pulse 77/min. Respiratory rate – 18/min, blood pressure – 135/73 mmHg. His oxygen saturation (SPO_2) was 100% on room air.

In general, the patient was conscious and well oriented to time, place and person, thinly built, seemed uncomfortable, was well dressed but not well groomed. He kept on moving here and there in the emergency ward. He sat still and winced when we spoke about his clinical condition. His speech was in high tone and volume. Mood was irritable. Ears and throat examination revealed no abnormality. He had poor oral dentition. During general physical examination, no evidence of lymphadenopathy or a carotid murmur was observed. His abdominal examination revealed tenderness with palpation in the epigastric region. There was no guarding or rebound tenderness. His abdomen was not rigid. Bowel sounds were quiet. The patient was thoroughly investigated. His hemoglobin level was 12.3 g/dl. White cell count was $4.2 \times 10^3/\mu L$ with 54% neutrophils. His metabolic panels were in normal range. Serum calcium levels were 8.2 mg/dl but serum amylase level was elevated at 290 IU/L, serum albumin level was 4.5 g/dl, triglycerides were 213 mg/dl, blood sugar levels 320 mg/dl, glycosylated Hb1c level was 8.1 (poor diabetic control). His viral markers were nonreactive for HIV and hepatitis B and hepatitis C serology. For detailed monitoring and investigations as well as treatment of alcohol dependence syndrome, the patient was admitted to psychiatry ward.

Initially, the patient was managed with intravenous fluids and thiamine 100 mg/day, lorazepam 8 mg/day, and haloperidol 10 mg/day to control the alcohol withdrawal and aggressive behavior. On 2nd day of admission, an extensive workup, including consultation with surgeon and gastroenterologist was undertaken. His detailed ultrasonography was done which showed atropic pancreas along with large cystic lesion in lesser sac which was likely to be pseudocyst pancreas. His CT scan abdomen was undertaken which showed cystic lesion in the body and tail region of the pancreas as pancreatic pseudocyst.

Gradually patient was shifted to oral medications and oral hypoglycemic agents. As the patient was started with oral risperidone 4 mg/day, he developed extra pyramidal symptoms as drooling of saliva, slurring of speech, and tremors in hands. The antipsychotic medication was stopped, and the patient was started with trihexypenidyl 4 mg/day, but patient went in delirium after 24 h of medications. The patient was shifted to Intensive Care Unit setting and managed conservatively by medical intensevist. Patient started showing recovery in the resolution of delirium condition within 3 days. The patient was again shifted back to psychiatry ward after the recovery of delirium condition.

Ultrasonography of abdomen was repeated after 1 week of treatment which revealed pseudocyst pancreas size which was 89 mm × 63 mm × 132 mm with the volume 387 cc seen in the region of body and tail of pancreas with uniform thick internal echoes with wall thickness 2.5–3.5 mm with normal uncinate process, head and neck of pancreas with normal splenoportal vessels. CT of the whole abdomen was undertaken by taking 5/10 mm contagious section from domes of diaphragm up to the pelvic outlet. Pancreas showed a well-defined cystic lesions in the body and tail region measuring approx 12.7 cc × 7.2 cc × 8.4 cc toward the greater curvature of the stomach. No solid component was seen, and no internal septations were observed. No foci of calcification were revealed on CT scan abdomen. The main pancreatic duct was not dilated much and head, and uncinate process of the pancreas showed normal enhancement.

The surgical opinion was taken at regular intervals, and surgical intervention was planned after the patient became medically stable and his serum amylase level and blood sugar levels were in normal range. His family members wanted to postpone surgical options for next 2 months and consent for surgery was not given by the patient and his family members. Finally, the patient recovered well from all his symptoms, and he was discharged without surgical intervention under satisfactory condition after 1 month of treatment. On regular follow-up in outdoor, patient had abstinence from alcohol and started his field work and started looking after his family and recovery was unremarkable.

DISCUSSION

Pancreatic pseudocyst is a common complication of alcohol-related pancreatitis, with potentially catastrophic complications and a difficult treatment course. In the published literature, it is reported that psedocyst pancreas can occur at any age from 7 months to 73 years, and the leading cause in adults is chronic alcoholic pancreatitis and trauma in children.[4] In the indexed patient reported in the above case, there was a formation of a pseudocyst of the pancreas after recurrent attacks of chronic pancreatitis that was due to heavy alcohol intake. Pseudocyst was localized in the region of body and tail of pancreas with uniform thickness. The disease was initially diagnosed echosonographically, then the exact localization of the pseudocyst and the anatomic relationship to other organs was confirmed during CT investigation.

The clinical course of the presented patient, the information on regular alcohol intake, and the chronology of events with a worsening of symptoms after the recurrent episodes of chronic pancreatitis are typical for pancreatic pseudocysts. The ultrasonography and CT examination of the abdomen are important for initial diagnosis of pseudocysts.[5] Literature revealed only a few scant reports of spontaneous resolution[6] but in the vast majority of cases, intervention was mandatory. The approach should be conservative treatment with strict diet, enzyme supplementation, and complete abstinence from alcohol is indicated to all stable patients. To date, surgery with or without pancreatectomy is the most commonly used treatment, alongside internal drainage of the stomach, or percutaneous drainage or transmural aspiration of other abdominal organs when applicable.[7-9]

Clinicians must maintain strict judicious use of antipsychotics and antiparkinsonian medications in such patients. Such patients are very sensitive to such medications. In this indexed patient, the small use of oral risperidone and trihexyphenidyl-landed patient into a delirium condition. In the proper management of patients of alcohol-induced pseudocyst pancreas with delirium, it is suggested that a multidisciplinary approach is adopted for achieving an optimal outcome.

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Conflicts of interest

There are no conflicts of interest.

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