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Case Report

Acute pancreatitis complicated by acute myocardial infarction – A rare association

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ABSTRACT

Acute pancreatitis complicated by acute myocardial infarction has been reported very rarely. The exact mechanism of the cause of myocardial injury is not known. We report a case of 36 year old male presenting with acute pancreatitis complicated by ST elevation acute myocardial infarction (AMI). The administration of thrombolytic therapy in such patients can have deleterious effects. We report successful performance of primary angioplasty in this complicated patient.

1. Introduction

Acute pancreatitis is an inflammatory disease of pancreas clinically characterized by epigastric pain and elevated pancreatic enzymes with multisystem involvement as a complication. The cardiovascular complications include shock, hypovolemia, pericardial effusions and non specific ST segment changes.

We report a case of 36-year-old male who developed an acute anterior wall myocardial infarction as a complication of acute pancreatitis. He underwent emergency coronary angiography and primary angioplasty successfully and survived the complication. To the best of our knowledge this is the first case reported in the medical literature.

2. Case report

A 36-year-old male patient was admitted to hospital with epigastric pain suggestive of pancreatitis,12 h after alcohol ingestion, in the middle of the night. He developed retrosternal chest pain, radiating to left arm (suggestive of ACS), 7 h after the onset of abdominal pain. The patient was treated for pancreatitis 2 months prior to this admission.

At admission, pulse rate was 110/minute and blood pressure was 180/120 mmHg. Physical examination revealed, epigastric tenderness with bilateral basal crepitations. ECG showed (Figs. 1 and 2), ST elevation in leads V1 to V4 and 2DEcho showed regional wall motion abnormality in LAD territory with LV dysfunction. Biochemical investigations showed, serum CKNAC 826U/L, CKMB 50U/L, serum amylase

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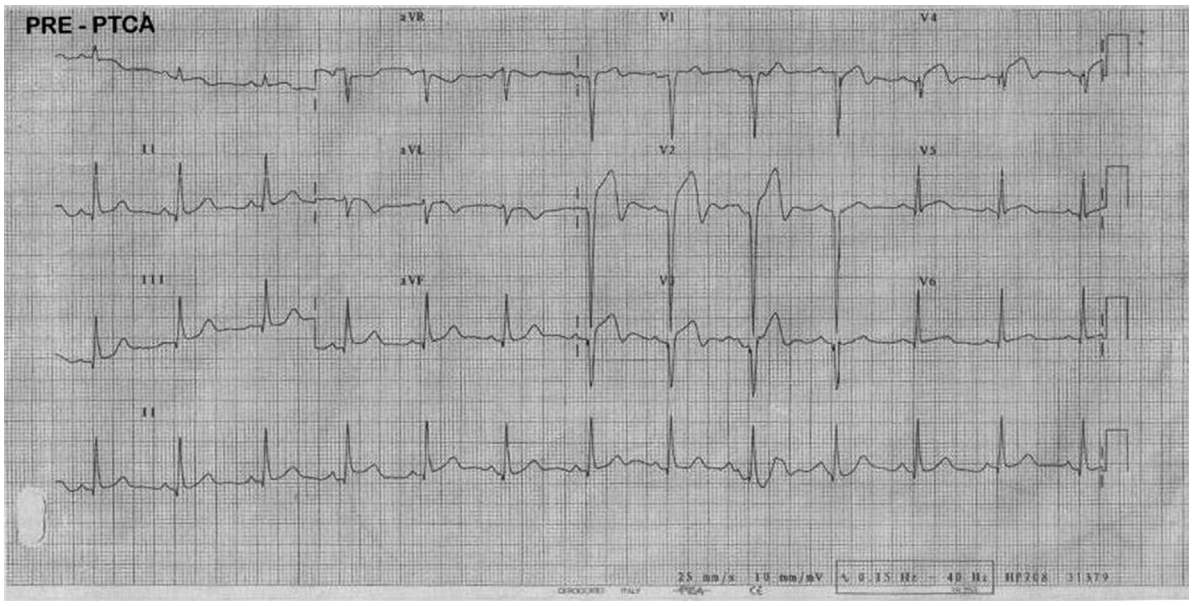

Fig. 1 – ECG showing acute anterior MI.

584 U/L and serum lipase 370 U/L. Ultrasound abdomen and CT scan abdomen (Fig. 3a and b) showed signs of acute pancreatitis.

Coronary angiography showed, total occlusion of mid LAD (Fig. 4a) with left circumflex and right coronary arteries being normal. Patient had persistent chest pain not relieved by nitroglycerine .He received Inj pethidine for analgesia. As the patient continued to have chest pain, primary angioplasty with stenting was contemplated with heparin alone. This patient received 600 mg of Clopidogrel with Disprin 350 mg loading dose, to be followed by Clopidogrel 75 mg and enteric coated Aspirin 325 mg per day. The lesion was crossed with 0.014″ × 180 cm guidewire and Bare metal stent (BMS) of 3.5 × 24 mm was implanted in the mid LAD (Fig. 4b). The coronary flow was TIMI grade II after implantation. He did not receive any GPIIb/IIIa inhibitors. Post stenting, he received intracoronary nicorandil, nitroglycerine to improve flow, followed by continuous intravenous administration. The patient had prompt relief of the chest discomfort after PTCA and did not have any recurrence. Post PTCA, patient had hematemesis following vomiting and did not receive any heparin subsequent to PTCA. Pancreatitis was managed with IV fluids and

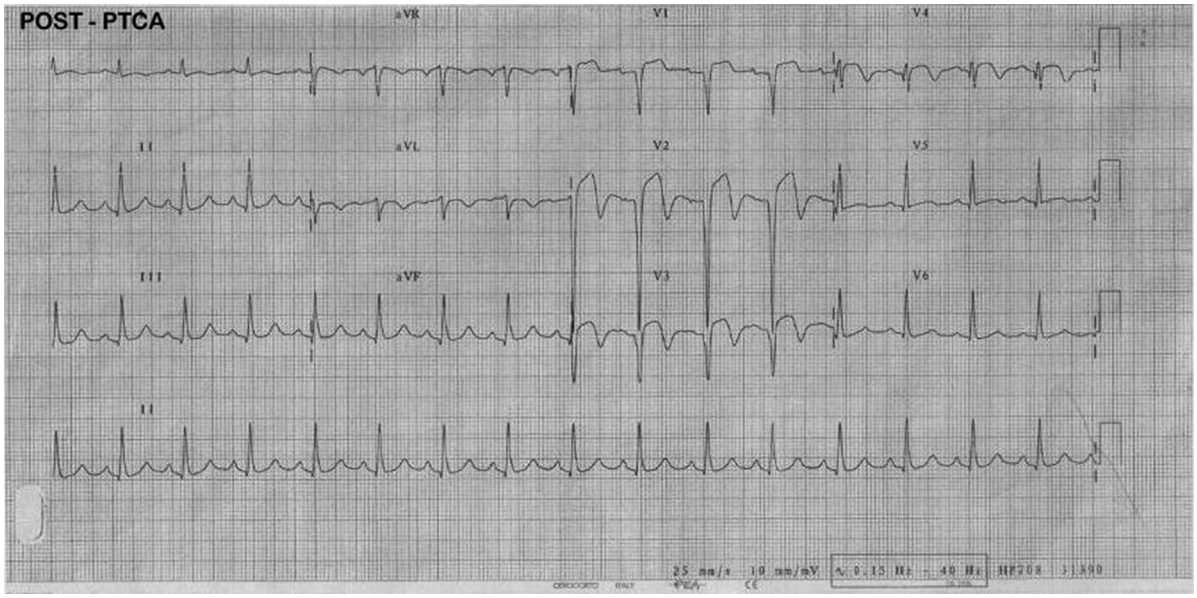

Fig. 2 – ECG immediately after PTCA.