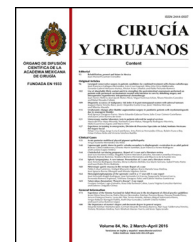




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CLINICAL CASE

Celiac block in paediatric patients using endoscopic ultrasound for management of severe pain due to chronic pancreatitis. Review of the technique in 2 cases[☆]



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KEYWORDS

Celiac block;
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Abstract

Background: Pancreatic diseases such as cancer, idiopathic recurrent pancreatitis, and chronic pancreatitis, can cause pain that is difficult to control. Pain is one of the most debilitating symptoms and demands increasing doses of analgesics and narcotics, as well as the number of hospital admissions, with a direct implication in the costs of medical treatments.

Objective: To describe the experience with 2 paediatric patients who were subjected to an ultrasound-guided endoscopic celiac ganglion block for difficult pain management, secondary to chronic pancreatitis disease.

Clinical cases: The first case concerns a 9-year-old male with a diagnosis of chronic pancreatitis, and the second case is a 12-year-old female who developed episodes of intermittent acute pancreatitis. Both cases suffered from chronic abdominal pain, which was difficult to control with stronger painkillers, such as opioids. The pain decreased after patients were subjected to an ultrasound-guided endoscopic celiac ganglion block.

Conclusions: This technique showed that both patients obtained satisfactory pain relief, with significant improvements in general symptomatology and the stopping of almost all analgesic

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medication. The authors suggest that celiac ganglion block must be considered, and implemented early before the usual complications, such as a consumption syndrome that is frequent in paediatric patients with chronic pancreatitis.

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PALABRAS CLAVE

Bloqueo celiaco;
Ultrasonido
endoscópico;
Pediátricos

Bloqueo celiaco en Pediatría mediante ultrasonido endoscópico para el manejo de dolor por pancreatitis crónica. Revisión de la técnica en 2 casos

Resumen

Antecedentes: Las enfermedades pancreáticas como el cáncer, la pancreatitis recurrente idiopática y la pancreatitis crónica pueden causar dolor de difícil control. El dolor es uno de los síntomas más debilitantes para los pacientes y demanda el incremento, tanto de analgésicos y narcóticos, como de la cantidad de ingresos hospitalarios, con implicación directa en los costos. **Objetivo:** Describir la experiencia de 2 pacientes pediátricos que fueron tratados mediante un bloqueo del ganglio celiaco guiado por ultrasonido endoscópico, para el tratamiento de dolor de difícil control secundario a pancreatitis crónica.

Casos clínicos: El primer caso se trata de un paciente masculino de 9 años de edad con diagnóstico de pancreatitis crónica. El segundo caso es una mujer de 12 años de edad que cursó con cuadros de pancreatitis aguda intermitente. Ambos casos presentaron dolor crónico abdominal de larga evolución y de difícil control con analgésicos potentes del tipo opioide. El dolor remitió posteriormente a que los pacientes fueran tratados mediante un bloqueo del ganglio celiaco.

Conclusiones: Mediante el bloqueo del ganglio celiaco, ambos pacientes obtuvieron resultados analgésicos satisfactorios, con mejoras importantes de la sintomatología en general y la suspensión casi en su totalidad de la medicación. Los autores proponen que el bloqueo del ganglio celiaco sea considerado e implementado de forma temprana antes de que se presenten complicaciones, como el síndrome consuntivo que es frecuente en pacientes pediátricos con pancreatitis crónica.

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Background

Patients with chronic pancreatitis seek medical care for abdominal pain or symptoms of bad digestion, such as chronic diarrhoea, steatorrhea, weight loss and fatigue.¹

Patients with chronic pancreatitis who present with pain state that it may be constant, intermittent and with occasional pain-free interludes. It has also been observed that eating exacerbates pain, which is why some patients even avoid eating so as not to feel pain, with consequent weight loss and physical impairment, that may even lead to wasting.²

The complexity and intensity of pain makes it difficult to control, which may trigger dependence on non steroid anti-inflammatory drugs (NSAID), and even narcotics. Several mechanisms have been described which explain pancreatic pain, for example: infiltration and inflammation of nerve sheaths and neural lymph nodes, increase in ductal and interstitial pressure, ulceration and secretion of neurolytic enzymes inside the pancreas, ischaemia and inflammation of the gland capsule, distal pancreatic stones or gallstones, sphincter stenosis and the presence of pseudocyst.³

Pancreatic pain is transmitted through the celiac plexus block which primarily contains sympathetic nerve fibres in a neural structure located in the upper half of the abdomen, which is anterior to the diaphragmatic cruris, slightly anterior and cephalic to the arterial celiac trunk, and opposite the vertebral bodies at levels T12 to L2; their posterior limit is L1 and the kidneys; lateral limits are the suprarenal glands and the inferior vena cava to the right and anterior pancreas⁴ (Figs. 1 and 2).

When pain does not respond to drugs or they lead to side effects such as nausea, constipation, anorexia, somnolence, confusion, dependence and addiction, a nerve block with alcohol may be administered which acts directly on the nerves that convey the painful stimuli from the diseased pancreas to the brain. The celiac trunk, splanchnic nerves or celiac ganglions are thus blocked.⁵

The splanchnic nerves which cross over the diaphragm, enter the abdominal cavity and form the celiac plexus also play a part in pancreatic pain. They may be reached percutaneously using a needle through the lumbar wall with a posterior approach or trans-abdominally with an anterior approach guided by computed tomography or ultrasound. With the advent of endoscopic ultrasound (EUS) new

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