INTRODUCTION

Trauma is the leading cause of death in children and adults up to age 44 years and kills more Americans age 1 to 34 than all diseases combined. (**Hoyt et al, 2002)**

Three to twelve percent of patients with sever abdominal trauma have pancreatic injury. Roughly two thirds of pancreatic injuries are the result of penetrating trauma, and the remaining one third is due to blunt trauma. **(Steer, 2004)**

Pancreatic trauma presents challenging diagnostic and therapeutic dilemmas to trauma surgeons. Injuries to the pancreas have been associated with reported morbidity rates approaching 45%. If treatment is delayed, these rates may increase to 60%. The integrity of the main pancreatic duct is the most important determinant of outcome after injury to the pancreas. Undiagnosed ductal disruptions produce secondary infections, fistulas, fluid collections, and prolonged stays in the intensive care unit and hospital. (**Subramanian et al, 2007)**

The clinical symptoms of abdominal pain, nausea, vomiting, and fever are not very specific to pancreatic injury. Furthermore, these symptoms do not correlate well with the severity of the damage. **(Bosboom et al, 2006)**

Contrast enhanced computed tomography scan is a useful modality for diagnosing, grading and following up patients with pancreatic trauma. (**Kantharia et al, 2007)**

MRCP has been advocated as a noninvasive method for diagnosing pancreatic ductal injury. **(Nirula et al, 1999)**

In most fatal cases early death is the result of hemorrhage from near by vascular structure while the second most common cause of death involves delayed mortality from intra abdominal sepsis. **(Steer, 2004)**

Although a majority of cases with pancreatic trauma respond to conservative treatment, patients with penetrating trauma, and associated bowel injury and higher grade pancreatic trauma require surgical intervention and are also associated with higher morbidity and mortality. (**Kantharia et al, 2007)**

The goals of operative therapy for pancreatic trauma, after resuscitation and thoroughly abdominal exploration, include control of hemorrhage debridement of non viable tissue with maximal preservation of viable pancreatic tissue and adequate drainage of exocrine secretion. **(Yeo and Cameron, 2001)**