Management of pancreatic trauma

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Pancreas is affected in sever abdominal trauma whether penetrating or blunt penetrating trauma such as stab wounds, gunshots wounds and shotgun wounds. Blunt trauma such as crush injury, blast injury or seatbelt syndrome which can be caused by one of the following forces: directimpact, deceleration, rotation, shear forces.The accurate and early diagnosis of pancreatic injury is important inorder to decrease morbidity and mortality. Delay in the diagnosis andintervention causes increased morbidity and mortality in pancreatictrauma. The retroperitoneal location of the pancreas contributes to thedelay in diagnosis as clinical signs may be masked and late in onset.Investigations that determine pancreatic injury includes serum amylaselevel, radiological assessment by plain abdominal radiographies,ultrasonography, computerized tomography, endoscopic retrogradecholangiopancreatography and magnetic resonance cholangiopancreatography.CT is the imaging of choice in hemodynamically stablepatients.Pancreatic injury can be categorized into five classes. Grade I: Minorcontusion without duct injury or superficial laceration without ductinjury, Grade II: Major contusion without duct injury or Major tissuelaceration without duct injury, Grade III: Distal transection orparenchymal injury, Grade IV: proximal transection or parenchymalinjury, Grade V: Massive disruption of pancreatic head.S UMMARY----------

--77If there is no evidence of a ductal injury on fine-cut CT, nonoperativemanagement is acceptable. Conservative management includes closeobservation and serial laboratory examinationsThe majority of patients with a grade I or II injury, in which bydefinition the pancreatic duct is intact, underwent exploration alone orwith drainage. Distal pancreatectomy was performed primarily inpatients with grade III injuries. Anterior and lateral pancreaticojujonostomyare used in grade IV injuries. Patients with combinedpancreatoduodenal are fortunately rare. Pancreaticoduodenectomy maybe required in a small group of patients with extensive tissue destructionthat couldn’t be repaired by simple primary repair.Complications of pancreatic injury are seen in 20-40% of patients’ andare higer in combined pancreaticoduodenal injuries. Commoncomplications are fistula formation, bleeding, pancreatic abscess,recurrent pancreatitis, and pancreatic pseudocysts.Pancreatic trauma in children is rare. Management stratigies arediverse and controversial. In general, management of pancreatic traumashould be individualized depending on the site of injury, timing ofreferral, presence of associated injuries and inistitutional expertise.It is concluded that early diagnosis & grading of pancreatic injury willhelp in choosing the suitable treatment which varies

from conservativemethods up to the surgical intervention.