ACUTE PANCREATITIS PRESENTING AS DIABETIC KETOACIDOSIS

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INTRODUCTION

Diabetic ketoacidosis (DKA) is an acute metabolic complication that occurs mainly in type 1 diabetes mellitus. People with type 2 diabetes can also develop ketoacidosis, but it is rare. It is usually triggered by a severe illness. Acute pancreatitis can present or coexist with DKA and aggravate its severity. The triad of diabetic ketoacidosis(DKA), hypertriglyceridemia, and acute pancreatitis(AP) is rarely seen.

METHODS

We present in these case of a 36-year-old female who presented with diabetic ketoacidosis, hypertriglyceridemia and acute pancreatitis with previously undiagnosed diabetes who had no significant elevation of amylase and lipase.

RESULT

A female patient aged 36 years old with no complaints and no history of disease had abdominal pain, neusea, vomiting followed by polydipsia and polyurea, dizziness and fatigue for the last 6 days. Her abdominal pain is diminished while sitting and bending forward. Her physical examination showed tender abdomen and dry mucosas. Her blood pressure was 116/72 mmHg, pulse was 118 beats/min, and temperature of 37.8 ° C. His labarotory examination showed 22.000 mm3 leukocytes, glucose 386 mg/dl, urea 48 mg/d, creatinine 0.96 mg/dl, triglycerides 1343 mg/dl and urine ketones +++, amylase 134 u/L (25125), lipase 112 u/L (878), blood pH was 7.27 (7.357.45).

Diabetic ketoasidosis treatment was started and oral intake was stopped. Her abdominal pain resolved and abdominal ultrasound showed increased pseudocyst appearance of 4.5x10 cm sized in the pancreas. After 15 days abdomen CT showed that, pancreas size was increased, lobulated, contours was irregular, hyperechoic, pancreas corpus and tail was atrophic(Figure 1). Lesion was reduced to a size of 56x46 mm. She was discharged with insulin therapy and switched to oral antidiabetics thereafter and is still on oral antidiabetics for the last 3 years.

CONCLUSION

Ketoacidosis can mimic acute abdomen and acute abdomen can cause diabetic ketoacidosis in a diabetic patient. But very rarely acute pancreatitis can present as diabetic ketoacidosis. Although moderate hypertriglyceridemia in DKA is common, if the TG level exceeds 1,000 mg/dL, the clinician should consider the devastating consequences such as acute pancreatitis At least in those patients with continuous abdominal pain, it is prudent to seek further laboratory evaluation or a CT scan of the abdomen.

In conclusion, normal lipase levels do not exclude the diagnosis of acute pancreatitis and imaging criteria may be needed. It is also important to recognize that laboratory studies have limitations, and these should be taken into account when confirming a diagnosis.