Dear Sir,

Acute pancreatitis is an infrequent but often lethal complication after kidney transplantation [1, 2]. A recent survey documented a mean incidence of 2.3% and a mean mortality rate of 61.3% [3, 4]. A multiplicity of factors may be responsible for the development of acute pancreatitis after kidney transplantation [3-5], which makes it difficult to identify the etiology. In addition, it is difficult to manage and treat this complication and preserve the graft function because of the immunocompromised condition. Recently, we successfully treated a kidney transplant patient with severe acute pancreatitis with cystic lesions with peritoneal lavage.

A 42-year-old man maintained on hemodialysis received a kidney from his mother. The patient was treated with a triple immunosuppressive regimen consisting of cyclosporin, azathioprine and methylprednisolone after transplantation. He did well and was discharged with a serum creatinine (s-Cr) level of about 2.0 mg/dl 1 month after transplantation. He developed upper abdominal pain and high fever and was admitted to the hospital again 2 months after transplantation. The abdomen was distended and some ascites was present. Tenderness was observed in the right hypochondrium. The allo-graft was not enlarged and not tender. An ultrasonography and a CT scan demonstrated a swelling of the head of the pancreas and an irregularity of the pancreas. Laboratory tests showed a serum amylase level of 1,100 U/L, an s-Cr level of 1.7 mg/dl and a white blood cell count of 10,200/mm3. The patient was diagnosed as having acute pancreatitis and received conservative therapy with FOY, antibiotics, adequate fluid supply, and food deprivation. During this episode, the s-Cr level gradually increased and then methylprednisolone bolus therapy was

Fig. 1. CT reveals enlargement and irregularity of pancreas head with large cystic lesion.
and peritoneal lavage was instituted. The catheter was introduced into the peritoneal cavity under local anesthesia and then about 2,000 ml of hemorrhagic ascitic fluid containing necrotic tissue of the pancreas was drained. Twenty to thirty liters of irrigation fluid per day were used in an initial phase. The volume of the irrigation fluid and the period of fluid collection in the abdominal cavity were controlled depending on the appearance of drained fluid and the abdominal condition. This procedure was repeated for 3 weeks until the drained lavage fluid became clear and the abdominal symptoms were relieved. Percutaneous drainage of pancreatic pseudocyst and retroperitoneal necrotic adipose tissue was performed simultaneously. Besides, about 2,000 ml of pleural effusion was drained by puncture of the pleural cavity. The patient responded to these treatments twice and azathioprine which was stopped due to leukopenia was readministered to maintain the graft function.

Thereafter, abdominal symptoms progressively worsened. Tenderness, defense and Blumberg’s sign appeared. Laboratory tests revealed a serum amylase level of 5,800 U/l, lipase 2,250/1, calcium 8.0 mg/dl, total protein 5.0 g/dl, total bilirubin 0.6 mg/dl, serum GOT 10 kU, serum GPT 15 kU, LDH 227 mU/ml, r-GTP 31 mU/ml, white blood cell count 11,000/mm3, hemoglobin 6.8 g/dl and hematocrit 20.6%. A CT demonstrated enlargement and irregularity of the pancreas, especially the head of the pancreas with a large cystic lesion, that were compatible with necrotizing pancreatitis. In addition, a peripancreatic and retroperitoneal fluid collection was observed (fig. 1). A deterioration of acute pancreatitis was diagnosed.

Peritoneal Lavage

- **FOY** (CT1)
  - 1900
  - s-Amylase 6,000-5,000 4,000-
Kidney Transplantation
3,000 -
(Discharge)
2,000 1,000
s-Amylase O-X 220 J40 WE
Fever up 4 4 4
Upper
Abdominal [plural]
Pain Effusion
4 ↓
(Re-admission)
4
1400
1100
Aprotinine ‘ Nicholine ‘
External Drainage
Puncture of Pleural cavity
\[\text{[CT]} \]
5880 Q \( \rightarrow \) 6880
» I
I I
\( \text{[CT]} \)
\[ \text{[CT]} \]
3060 (CT) Q \( \rightarrow \) I j
900
\( \text{[CT]} \)
1100 \( \rightarrow \) O →
700
(CT2)
(Discharge)
4
360
0 0
months
Post-Transplant
Fig. 2. Clinical course. CYA = Cyclosporin; AZ = azathioprine; MZ = mizoribine; MP = methylprednisolone.
ments and his abdominal and general condition gradually improved. The serum amylase level decreased and was maintained at about 700 U/l. The s-Cr level was also maintained at about 1.5 mg/dl during and after peritoneal lavage. A CT showed the disappearance of the swelling and the irregularity of the pancreas and pancreatic cyst. The further recovery of the patient was uneventful and the renal function remained stable (fig. 2).
Since acute pancreatitis often leads to organ failure including graft failure in the transplant patients, early treatment and an adequate choice of treatment modality are required to preserve the graft function. Especially, in a case with multisystem failure, intensive care with blood purification is essential. Peritoneal lavage could remove ne-crotic pancreatic tissues.
and toxic substances in the pancreatic peritoneal exudate from peritoneal cavity and reduce
the edema of the pancreas. The peritoneal lavage therapy could also keep the circulatory
condition
stable and remove uremic toxins in combination with peritoneal dialysis. Ranson et al. [6],
Kauste et al. [7] and Lasson et al. [8] observed the efficacy of peritoneal lavage on severe
acute pancreatitis in nontransplant patients with severe disease.
In our renal transplant case, peritoneal lavage and dialysis had a good result and did not
influence the circulation and function of the graft. Our results suggest that peritoneal lavage
may be a useful treatment for severe acute pancreatitis that could not be treated
conservatively after renal transplantation.

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