**Case report No 12**

Case presentation

A 52-year-old Caucasian man was referred to the 4th Department of Internal medicine for vomiting and abdominal pain.

Family history: His father, 80-year-old, suffered from coronary heart disease and was operated on for cholelithiasis (bile stones). His mother, 79-year-old, was treated for diabetes mellitus type 2. His younger brother and two children did not have history of any serious medical illness.

Occupational history: He works as a bank clerk.

Personal history: Apart from a history of lower back pains, due to lumbar degenerative disc disease; his medical history was unremarkable with no preexisting conditions. There was no regular medication. He denied any regular alcohol consumption as well as cigarette smoking.

Present illness: At the day of admission, he attended a birthday party in the late afternoon. At the party, he consumed fatty and sweet foods and some alcoholic drinks. Three hours later, he had a pain in the umbilical area which was accompanied by vomiting of undigested food.

After another three hours there was a significant dull pain, appearing in the epigastric and umbilical area radiating to his back. Vomiting repeated without any relief. He had no fever, dyspnea or other problem.

Due to the increasing intensity of abdominal pain, he called an ambulance which took him to the emergency room of the General Faculty Hospital.

The physical examination revealed painful grimaces of the face, the patient was generally altered, reddened in the face, lying on the left side, with marked flexion in the hip joints and pulling of the knees towards the abdomen. He was afebrile, his pulse rate was 92 beats per minute and his blood pressure was 120/80 mm Hg. Examination of the heart and lungs were unremarkable.

The abdomen revealed a symmetrical movement of the abdominal wall during breathing, there was a differential tympanic percussion. There was a diffuse pain after palpation with a maximum in the umbilical area. Peristaltic sounds were normal and blunted. There were no signs of peritoneal irritation. Rectal examination revealed slight sensitivity in Douglas space. The Murphy´s sign was negative.

Laboratory findings (normal range): ESR 28/42 (2-9/6-20); WBC 17.5 x 109/1 (4.0-10.0), RBC 4.8 x 1012/1 (4.0-5.8), total bilirubin 26 μmol/1 (2.0-17.0), AST 0.82 (0.10-0.72)

μkat/1, ALT 0.85 (0.10-0.78) μkat/1, GGT 1.3 (0.14-0.84) μkat/1, ALP l.9 (0,67-2.15) μkat/1, CRP 102 (0.0-5.0) mg/l; glucose 7.8 (3.9-5.6) mmol/1, serum amylase 9.9 (0.00-0.88) μkat/1. Urine analysis was negative in relation to the presence of bilirubin, urobilinogen, glucose, and ketone bodies.

Imaging: Plain film radiography of the abdomen revealed a slowed down peristalsis without a sign of pneumoperitoneum.

The abdominal ultrasound showed a swelling of the pancreas, however, no signs of biliary and liver disease or gallstones.