

췌장 복용에 의해 발생한 급성 간염이 동반된 급성 췌장염의 예

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서론: 급성 췌장염은 대부분 술이나 담석에 의해 발생하지만 드물게 약제에 의해 발생할 수 있으며 ACE inhibitors, statins, Hypoglycemic agents, anti-HIV medications 등 약제에 의 한 급성 췌장염이 보고되고 있으나 한약, 건강식품, 민간요법에 의해 급성 췌장염이 발생된 경우는 매우 드물게 보고되고 있다. 건강식으로 췌을 복용한 후 급성간염이 동반된 급성췌장염 발생한 예가 있어 보고한다. **증례:** 60세 남자 환자가 3일전부터 발생한 LUQ pain 주소로 내원 15일전부터 췌 매일 복용, no alcohol, no smoking, no med. PE: alert V/S 130/70 mmHg - 70 - 16 -38.3°C, Acute ill looking appearance Anicteric sclera Abdomen soft T/rT(+,LUQ/-) Normoactive BS 치료 및 경과 췌 복용에 의한 급성간염이 동반된 급성췌장염으로 생각되어 입원하여 금식 및 TPN, 열 동반되어 ceftriaxone 2g qd 시행 입원치료 3일째 AST 49IU/L, ALT 106IU/L, T.bil 1.56mg/dl, amylase 149IU/L, Lipase 298IU/L, CRP 6.17 감소 입원치료 4일째 상복부 통증 호전, 식사 위하여 soft diet 시작 입원치료 6일째 AST 40IU/L, ALT 63IU/L, T.bil 0.65mg/dl, amylase 100IU/L, Lipase 258IU/L CRP 3.66 감소, 복부증상 없어 퇴원 **고찰:** 급성 췌장염이 약제에 의해 유발되는 경우는 전체 급성 췌장염의 0.1-2.0%에 불과하여 간과되기 쉽다. 약인성 췌장염은 첫째, 약제의 사용 이후 췌장염이 발생 선후관계인정 둘째, 췌장염을 유발할 다른 원인(담석, 알코올, 고중성지방혈증 등)이 배제 셋째, 약제를 중단한 이후 증상호전, 넷째 가능하다면 원인으로 생각되는 약제를 다시 투여하여 췌장염이 재발하는 것을 확인하여 진단할 수 있다. 원인 미상의 췌장염이 발생한 경우 한약, 건강식품 등에 의해 발생했을 가능성이 있다는 것을 염두에 두고 자세한 병력 청취가 필요하다.



Figure 1. Whole Abdomen CT(enhance)
Acute pancreatitis with small amount of peripancreatic fluid collection

Table1. Admission lab					
WBC(μ l)	7,630	AST(IU/L)	188	T.bil(mg/dl)	3.98
Hb(mg/dl)	14.9	ALT(IU/L)	238	Amylase(IU/L)	744
Plat. (μ l)	143,00	ALP(IU/L)	268	Lipase(IU/L)	711
CRP(mg/dl)	9.47	r-GTP(IU/L)	1198	igG4(mg/dl)	31.2
				HBs Ag	-
				HCV Ab	-
				HAV IgM	-

Negative relationship between calf muscle cross sectional area and venous thromboembolism after TKR

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Background/Aims: Venous thromboembolism (VTE) is a serious complication after total knee replacement (TKR), and recent guideline recommends thromboprophylaxis for VTE after TKR. Previous studies have reported VTE occurred in 5 to 10% of patients underwent TKR despite adequate prevention. Stimulation of the calf muscle pump function is known to be beneficial to VTE prophylaxis. However, it is unknown whether there is a correlation between calf muscle mass and incidence of post-operative VTE. In this study, we hypothesized that there is correlation between calf muscle cross sectional area (CSA) and incidence of VTE after TKR. **Methods:** We retrospectively enrolled 224 patients underwent TKR. The enhanced pulmonary artery and lower extremity CT scan was routinely performed in all patients at post-operative 5 day. Calf muscle CSA was measured using CT cross sectional image at the maximally thick calf muscle and CSA of tibia and fibula was subtracted. **Results:** Among of 224 patients, 90 patients (40.7%) were diagnosed as deep vein thrombosis (DVT) or pulmonary embolism on CT scan. Two-cases of VTE extended to main pulmonary artery, 35 cases of VTE extended to major pulmonary branch, and 23 cases had only DVT. There were no significant differences in baseline characteristics between both groups with or without VTE. Calf muscle CSA was higher in the non-VTE group, but it was not statistically significant (Non-VTE 5361.0 ± 1069.9 mm² vs. VTE 5097.2 ± 939.9 mm², $P=0.059$). By ROC curve analysis of calf muscle CSA, the cut-off value at 5057.0 mm² showed sensitivity of 60.4% and specificity of 55.6% for negative prediction of VTE (AUC: 0.590, CI: 0.51-0.66, $P=0.022$) (Figure 1). Multivariate analysis showed high calf muscle CSA (CSA value ≥ 5057 mm²) was associated with 46.4% reduced risk of VTE after adjustment for significant variables. **Conclusions:** The present study shows a higher incidence of VTE (40.7%) after TKR in patients with thromboprophylaxis than that of previous studies. Furthermore, calf muscle CSA had negative relationship with VTE. Therefore, calf muscle CSA can be a simple and useful method for post-operative VTE risk stratification.

Figure 1. ROC curve of calf muscle cross sectional area for negative prediction of venous thromboembolism after total knee replacement surgery

