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Commentary Article

Pancreatitis, Panniculitis, Polyarthritis (PPP) Syndrome Caused Post-Pancreatitis Mesenteric Vein Necrosis

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DESCRIPTION

Pancreatic disease can rarely express itself by extra-abdominal pathological processes. The symptomatic triad of pancreatic disease, panniculitis and polyarthritis, also known as PPP syndrome, is characterized by severe chronic episodes and high mortality rate. The pathognomic hallmark of PPP syndrome is fat necrosis in affected tissues. It is essential to identify its indicators due to complicated diagnosis procedure as a result of absent or mild abdominal symptoms.

Ascites, excessive oedematous changes in multiple organs were identified, whereas no pancreatic parenchymal changes were observed. Finally, this condition was named as PPP syndrome. Knowledge of association between panniculitis and polyarthritis with acute pancreatic disease may lead to a prompt diagnosis and management. Histopathological features of skin lesions can be a valuable clue for focusing attention to a pancreatic disease

Pancreatitis, panniculitis and polyarthritis syndrome (PPP-syndrome) may be a very rare symptom complex of additional pancreatic manifestations of pancreatitis with lobular panniculitis and (poly-) arthritis with intra osseous fat necrosis. Although the pancreatic pathology with exceptional high blood levels of pancreatic enzymes (in particular lipase) is widely considered causative, abdominal symptoms are often mild or absent. This results in misdiagnosis, delay of appropriate therapy and worsening of prognosis [1].

Herewe report a case of PPP-syndrome with extensive intraosseous fatnecrosis in multiple bones and polyarthritis. Outstanding in thiscase was the extremely high blood level of up to 600-fold ele-vated lipase caused by a pancreatic pseudocyst with contact and signs of pancreatitis in clinical symptoms, computed tomographyand ultrasound it had been not related with the opposite symptoms By thistreatment, the elevated lipase levels and CRP-values were normal-ized, but joint pain was only partially reduced. After 2 weeks, thepatient was readmitted with heavy pain in his left knee withdistinct swelling and reddening.

In minor extent, he suffered alsofrom pain within the left shoulder, wrists, cubital and both ankle joints.He added that 9 months ago, he suffered from similar symptomswith multiple joint pain. The patient had a history of acute, necro-tizing head-pancreatitis caused by heavy alcoholic abuse 3 years ago,but now he clearly negated any abdominal symptoms and was plau-sibly abstinent of alcohol.

A cystic lesion of the uncinate process of the pancreas with constant size was described in imaging for 3years. A key learning point is that the high value of vena mesenterica thrombosis as an indirect radiological sign of tiny fistulas. A PPP-syndrome has got to be taken into consideration if the origin of any osteonecrosis, polyarthritis or panniculitis remains unclear, considering the high morbidity and mortality. Absent abdominal symptoms can delay the diagnosis of the underlying pancreatic disease.

Measuring of lipase, skin or bone biopsies, which showpathognomonic features, and if appropriate surgical explorationare the foremost important diagnostic procedures. counting on thekind of the underlying pancreatic disease correct treatment can besuccessful and cause complete remission.

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