A 32-year-old male patient presented to the outpatient clinic at Nishtar Hospital, Multan, Pakistan, with a history of re-lapsing fever, sore throat, productive cough, myalgia, and diarrhea for 1 week. The patient was a medical physician currently working in the medicine ward. He did not report any prior comorbidities or high-risk travel history.

Considering the exposure history, a reverse transcriptase-PCR for COVID-19 was obtained. Initially, the patient’s temperature was 38°C, the blood pressure 110/80 mmHg, the pulse rate 110 beats per minute, the respiratory rate 16 breaths per minutes, and oxygen saturation 99–100% while breathing in ambient air. He was managed with simple supportive measures. After 21 hours, his tests for COVID-19 were reported positive. The patient chose to self-isolate at home until his symptoms subsided and his results came negative. He was advised to report to the emergency department in case of severe dyspnea, chest pain, cyanosis, or altered mental status.

A week after the diagnosis, the patient reported to the emergency department with severe mid-epigastric pain radiating to the back accompanied by intermittent high fevers, diarrhea for 1 week. The patient was a medical physician currently working in the medicine ward. He did not report any prior comorbidities or high-risk travel history.

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regarding its extrapulmonary symptoms are still evolving. With the increase in the number of cases and accumulation of data on possible signs and symptoms, it appears that gastrointestinal symptoms are fairly common in COVID-19 patients. A comprehensive study conducted in Hubei, China, evaluated 204 patients who tested positive for COVID-19, of whom 50.5% reported some gastrointestinal disturbance such as diarrhea, anorexia, vomiting, or abdominal pain. A rare group of patients presented with gastrointestinal symptoms only without any respiratory symptoms.3

In our case, the diagnosis of pancreatitis in this patient appears to be idiopathic in the absence of comorbid conditions, cholelithiasis, alcohol usage, trauma, or recent invasive procedures such as endoscopic retrograde cholangiopancreatography. However, around 10% of cases are due to miscellaneous factors such as viral, bacterial, or parasitic infections. Notably, Coxsackievirus, herpes simplex virus, mumps, human immunodeficiency virus, and Mycoplasma, among several others, are responsible for causing infectious pancreatitis.4 Similar cases have been reported recently from Newport (United Kingdom) and Denmark, where multiple patients with COVID-19 disease presented with complaints of acute pancreatitis.5,6 A study in Wuhan city showed the prevalence of pancreatic injury in nine of 52 patients admitted in a hospital. It suggested that the pancreatic injury could be due to heavy expression of angiotensin converting enzyme or harmful systemic immune response induced by COVID-19 infection.7 Based on this case and the aforementioned studies, we recommend further studies to be conducted to evaluate any possible association between COVID-19 and acute pancreatitis.

CONCLUSION

This is a case describing the incidence of pancreatitis in a COVID-19–positive patient. We encourage medical practitioners to carefully evaluate gastrointestinal symptoms and measure serum amylase and lipase levels in patients presenting with abdominal pain and COVID-19.

Received June 1, 2020. Accepted for publication July 1, 2020.

Published online July 8, 2020.

Acknowledgment: Publication charges for this article were waived due to the ongoing pandemic of COVID-19.

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