ASTS 7th Annual Fellows Symposium
Pancreas Case Studies
Friday, October 4, 2013

Pancreas Case #1
42 y/o male with IDDM since age 12 and ESRD requiring HD for the past 3 months. HA1C is 7.5 and he is on an insulin pump – total daily usage 60U. Other complications from DM include retinopathy, neuropathy and gastroparesis. He makes 1-2 cups of urine daily. He walks daily but gets short of breath after 1 block. BMI is 30. His femoral pulses are easily palpable. His C-peptide is undetectable and anti-GADab is positive. He has 2 potential living kidney donors. He is interested in kidney and pancreas transplant.

- Is he a transplant candidate? For kidney, pancreas, or both?
- Do you recommend living donor kidney transplant, SPK, or another option?
- What workup would you do if any?
- What are your criteria for SPK, PAK, or PTA? Are they different?

Pancreas Case #2
For each of the following donors, indicate whether you would use the pancreas for all candidates; refuse for all candidates, or use only for certain candidates or transplant types (SPK,PAK,PTA):

1. 22 y/o female, COD trauma, BMI 25, no PMH. Normal amylase/lipase/glucose, creatinine 2.0, requiring moderate doses of levophed, vasopressin. Intraop: moderate retroperitoneal edema.
2. 34 y/o male, BMI 34, COD cerebral hemorrhage, no PMH. Normal amylase/lipase, creatinine 1.5. Requiring 1u/hr insulin, HbA1c 5.8. Hemodynamically stable. Intraop: moderate peripancreatic fat.
3. 50 y/o male, BMI 28, COD trauma, PMH 3 yr HTN, heavy drinking history. Amylase/lipase/glucose normal. Creatinine 1.3. Hemodynamically stable.
4. 30 y/o female, BMI 30, COD CVA, no PMH. 15 min downtime, now stable. Amylase 600, lipase 450, Creatinine 1.2. Has required 8u insulin/24 hr.
5. 28 y/o male DCD, BMI 25, COD trauma, no PMH. Normal amylase/lipase/glucose, Scr 1.2. Hemodynamically stable.
6. 22 y/o male, COD trauma, BMI 25, no PMH. Normal labs and hemodynamics. Has history of IV drug use – last known use 4 weeks ago, no track marks. Serologies and NAT testing are negative.

Pancreas Case #3
29 y/o female s/p SPK 6 weeks ago is seen in clinic for routine follow up. She complains of decreased appetite, nausea and mild abdominal discomfort. She has lost 5 kg since discharge. Her vitals are HR 95, BP 92/58, and RR 12/min. On exam her abdomen is mildly distended and tender in the RLQ without peritoneal signs.

Labs include fasting glucose of 185, creatinine of 1.8 (1.2 week prior) and serum amylase 115 and lipase 138. She is on Tacro/MMF/pred and Tacro levels have ranged from 4-16 (most recent 8).

- What is your differential diagnosis?
- What workup would you do?
- What is your management plan?

Pancreas Case #4
45 y/o male with type I DM and s/p living related renal transplant 2 years prior. He is called in for PAK transplant after an appropriate donor pancreas is accepted. He has good renal graft function. He has a history of DVT and is on 325mg ASA and Coumadin with an INR of 2.0.

- Will you perform pancreas transplant in a patient requiring anticoagulation with Coumadin? Antiplatelet agents?
- Do you screen for thrombophilia in pancreas transplant candidates?
- Do you reverse his anticoagulation? If so, how?

During the operation he has significant oozing not responsive to various hemostatic measures and he gets 2 units FFP and 2 units PRBC. The operation is otherwise unremarkable. The glucose normalizes after reperfusion.

- Do you anticoagulate post-op?
- If so, what drug do you use, when do you start?
- Would your answer be different if there was no intraoperative bleeding?

Case #5
A 34 y/o woman with Type 1 DM, ESRD for 2 years. She receives SPK transplant with bladder drainage and systemic venous drainage. Received Thymo/tacro/MMF/pred. Both organs had immediate function; post-operative course was uncomplicated and was discharged POD 5 with normal glucose/amylase/lipase/ SCr 1.0

She returns to ER POD 9 with nausea, poor po intake, mild pelvic pain. PE: tachycardia, no abdominal tenderness.
Labs: WBC 11.2, BUN 44, Cr 2.1, Amylase + lipase normal, glucoses 100-200. UA 10-50 WBC/10-50 RBC, pos leukocyte esterase, neg nitrites. Tacro 12.5 ng/ml.

- What is the most likely cause of the patient's symptoms?
- What is the most appropriate next step?
- Would you management be different if there were abdominal symptoms/findings?

She was admitted and received IV antibiotics and hydration. Creatinine declined to 1.1, po intake improved. D/c'd home hospital day 3. Returns to clinic after 4 days with fatigue, lightheadedness. HR 100, BUN 44, Cr 1.6. UA normal, tacro 13.2 ng/ml.

- What is the most likely cause of her renal dysfunction?
- How would you evaluate and treat this?