A 24-year-old male patient with prior history of anxiety, depression, hyperlipidemia presented with epigastric pain for the last 24 hours associated with nausea and vomiting. Her epigastric pain was sharp, severe with radiation to her back. There was no relation to food. He denied fever, chills, weight changes, diarrhea, constipation, jaundice, hematemesis, hematochezia, melena, chest pain, shortness of breath, or cough. He had no previous history of pancreatitis. He underwent cholecystectomy four years ago. No family history of pancreatitis. His parents were in the room with him. He denies any tobacco or alcohol use. Home medications include lorazepam and ambien. Physical exam significant for anxious male, tenderness in the epigastric area and bilateral gynecomastia. Labwork showed normal WBC. Mild transaminitis with AST 80 and ALT 65. Lipase was 890. Triglyceride 180. Serum calcium 8.8. What is the most likely etiology?

A. Hypertriglyceridemia-induced pancreatitis  
B. Hereditary pancreatitis  
C. Cannabis-induced pancreatitis  
D. Spironolactone-induced pancreatitis  
E. Cystic fibrosis

Answer: C
The patient has normal TG with no family history of pancreatitis. Patient has no clinical presentation consistent with cystic fibrosis. Patient is not on spironolactone and the medication is not associated with pancreatitis. This is a young anxious male with family at bedside. Given clinical feature of bilateral gynecomastia should raise suspicion for cannabinoid-induced pancreatitis.