Pancreatitis

Handout compiled by Moses Murdock (@haematognomist)
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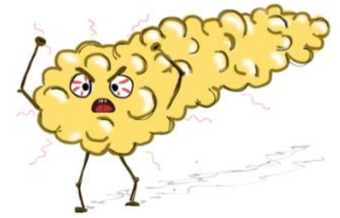

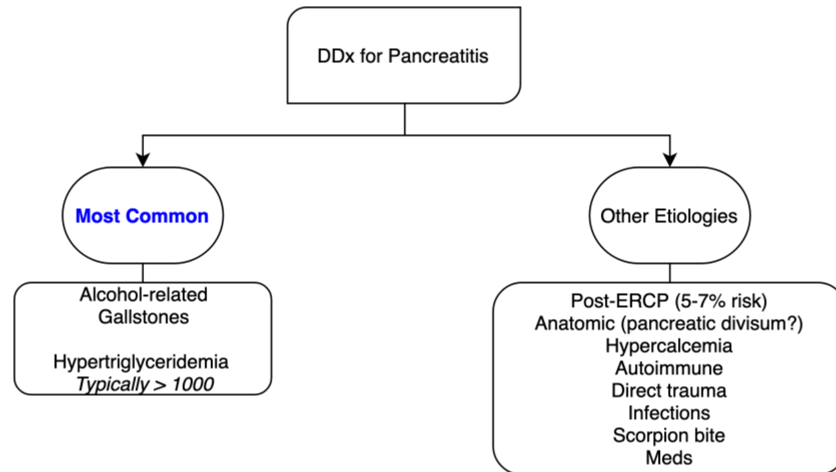

1. **Overall Approach**
   - Diagnostic Criteria = 2/3 of the following:
     - Clinical presentation: epigastric pain to the back, nausea, vomiting
     - Biochemical pancreatic inflammation: lipase/amylase > 3X upper limit of normal
     - Radiographic: CT with IV/PO contrast (US and MRI other options)
   - Severity, can use scores: SIRS, BISAP
     - Mild: no end-organ failure or systemic complication
     - Moderate/Severe: local complications or persistent organ failure
     - Elevated Hg, BUN, Cr: worse prognosis given intravascular volume depletion

2. **Management:**
   - NPO: bowel rest.
     - Advanced diet if: pain is improving, no signs of ileus. **Enteral feeding preferred**
     - Mild: low fat/solid diet (no need to start with clears)
     - Moderate-Severe: 3 days of NPO ok, then enteral feeding if unable to take PO
   - Fluid resuscitation:
     - Aggressive, maintenance 250-500cc/hr – **within 24h**, then start peeling back
     - Consider Foley to monitor, **goal 1 cc/kg/hr urine output**, trend Hg, Cr, BUN
   - Pain control
   - Diagnostic studies:
     - Liver enzymes (cholestatic pattern?)
     - Fasting lipids
     - RUQ abdominal ultrasound
     - CT scan: contrast in an intravascularly dry patient is risky. Get if you think something else is going on, or complications develop. **NOT** up-front.
   - Watch for complications:
     - CBD stone, think about ERCP (not up-front, trend LFTs – unless cholangitic!)
     - Acute complications: ARDS, SMV thrombosis, electrolytes, volume from IVF
     - Subacute (few days): fluid collection, pancreatic necrosis
     - Longer (> 4 weeks): pseudocyst, abscess, chronic pancreatitis