

PANCREATITIS

Overview: 4.8-24.2/100,000 persons

- 2 most common causes alcohol and gallstones (hyperlipidemia, infection(mumps), trauma, drugs-55 mostly anecdotal reports-sulfonamides, 6mp, AIDS, asacol, 5-ASA)

- Ranson's Criteria:

Immediate

Age >55
WBC >16,000
Glucose >200
LDH >350
AST >250

After 48 hours

HCT <10
BUN >5
Ca⁺⁺ <8
PaO₂ <60
Base Deficit <4
Fluid retention >6 L

(sensitivity 57-85%) >6 signs mortality is 60%

- injury to the acinar cells, activation of trypsin > clearance
- Pathogenesis of gallstone pancreatitis is unknown: reflux of bile from incompetent sphincter, or the common channel theory are popular theories. Impacted stones may cause increased ductal pressure
- SIRS and ARDS likely from release of enzymes into circulation

Predisposing conditions:

Stones 35% of pancreatitis-but only 3-7% with stones go on to develop pancreatitis

Sludge microlithiasis and sludge more likely to pass thru the cystic duct

Diagnosis-ALT >150 95% positive predictive value, Ultrasound

Treatment:

Mild-Bowel rest, IVF, nasogastric tubes not beneficial in mild pancreatitis, nor are acid blocking agents

Severe-ICU, aggressive hydration to prevent further pancreatic injury/SIRS and MODS balance with overhydration in setting of renal failure, CHF, and cardiac failure, infection occurs in 30%

Antibiotics- Prospective trial in setting of 1/3 pancreatic necrosis-antibiotics dec'd mortality 3 vs 23% (Imipenem, 3rd gen. Ceph, Quinolones)

Laparoscopic Cholecystectomy- General teaching is that should be performed before discharge as up to 1/2 will develop recurrent attacks within 2 months if discharged

Debridement: Infected pancreatic necrosis-mortality 10-50%, CT diagnosis and cultures, future roles for endoscopic or interventional drainage procedures?

References:

- **Kaw et al GI-Endoscopy(2002)-**
 - prospective observational study 134 patients
 - 83 had cholecystectomy and ERCP +/- ES(endoscopic sphincterotomy)-
 - 34 patients had ERCP/ES alone-
 - Recurrent pancreatitis: 2.4% vs. 2.9%
 - So can ES be used as definitive Rx?
- **Kozarek (GI Endoscopy 12/2002)-**
 - Reviewed 4 prospective trials on role of ERCP-1988
 - British study of 121patients: 1993
 - Hong Kong Study: 1995
 - Polish Study
 - German study: 1997
 - conclusions were pre-cholecystectomy ERCP for:
 - Cholangitis
 - Obstructive Jaundice
 - in-hospital exacerbation
 - severe pancreatitis
 - post cholecystectomy ERCP for retained stones/smoldering disease (sphincter dysfunction)

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