

New Guidelines Released for Acute Pancreatitis Management

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The American College of Gastroenterology has issued updated guidelines on the diagnosis, workup, nutrition, and management for patients with acute pancreatitis (AP). The new recommendations were [published online](#) July 30 and in the September issue of the *American Journal of Gastroenterology*.

AP is one of the most prevalent gastrointestinal diseases, and prevalence has been increasing in recent years. The AP case fatality rate has fallen over time, but there has been no change in the overall population mortality rate.

Within 1 week of onset (early AP), a systemic inflammatory response syndrome (SIRS) and/or organ failure may develop, and subsequently (after 1 week), there may be local complications.

"In order to be properly diagnosed with acute pancreatitis the pain should be severe," lead author Scott Tenner, MD, MPH, director of the Greater New York Endoscopy Surgical Center and associate professor of medicine at the State University of New York, said in a news release. "Patients can be falsely diagnosed if the criteria are not followed. In addition we recommend that a CT scan only be performed for patients when their diagnosis is not clear or if they have not had improvement 48-72 hours after hospital admission."

Two of the following 3 criteria should therefore be present to diagnose AP:

1. characteristic (severe) abdominal pain,
2. serum amylase and/or lipase exceeding 3 times the upper limit of normal, and/or
3. characteristic abdominal imaging findings (strong recommendation, moderate quality of evidence).

"During the past decade, there have been new understandings and developments in the diagnosis, etiology, and early and late management of the disease," the guidelines authors write.

Specific Recommendations

- On presentation, patients should immediately be evaluated for hemodynamic status and receive necessary resuscitative measures.
- Patients with AP should receive early, aggressive intravenous hydration, under close observation, unless contraindicated by cardiovascular and/or renal comorbidities. This intervention is most effective within the first 12 to 24 hours but may be of little benefit thereafter.
- Patients with AP and concurrent acute cholangitis should undergo endoscopic retrograde cholangiopancreatography (ERCP) within 24 hours of admission. This procedure combines upper endoscopy and radiography to delineate and intervene in problems affecting the bile and pancreatic ducts.

- To reduce the risk for severe post-ERCP pancreatitis, high-risk patients should receive pancreatic duct stents and/or postprocedure rectal nonsteroidal anti-inflammatory drug suppositories.
- Clinical symptoms and laboratory findings typically allow AP diagnosis. Therefore, pancreatic contrast-enhanced computed tomography and/or magnetic resonance imaging should be performed only in patients in whom the diagnosis is unclear or who do not improve clinically.
- Whenever feasible, patients with organ failure and/or SIRS should be admitted to an intensive care unit or intermediary care setting.
- In patients with severe AP and/or sterile necrosis, routine use of prophylactic antibiotics is not recommended.
- Antibiotics known to penetrate pancreatic necrosis may reduce morbidity and mortality in patients with infected necrosis, thereby delaying intervention.
- Patients with mild AP without nausea and vomiting can immediately start oral feedings.
- Patients with severe AP should receive enteral nutrition to prevent infectious complications. However, parenteral nutrition should be avoided in these patients.
- No intervention is needed for asymptomatic pancreatic and/or extrapancreatic necrosis and/or pseudocysts, regardless of size, location, and/or extension.
- Stable patients with infected necrosis should delay surgical, radiologic, and/or endoscopic drainage, preferably for 4 weeks, to allow time for a wall to develop around the necrosis.

The guidelines also provide recommendations for determining the etiology of the condition, including evaluation of all patients with transabdominal ultrasound.

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