GUIDELINES FOR **MANAGEMENT** OF PATIENTS WITH ACUTE PANCREATITIS (Reference B)

Patient meets criteria for acute pancreatitis and initial diagnostic evaluation completed (See "Guideline for Diagnosis and Stratification of Patients with Acute Pancreatitis")

Mild Gallstone Pancreatitis | Severe Gallstone Pancreatitis | Mild Non-Gallstone Pancreatitis | Severe Non-Gallstone Pancreatitis

Recommended Diagnostic Studies, **day 1 & 2** after admission - recommended for ALL pts to determine severity of pancreatitis (after day 2, individualize based on pt's clinical status) :

- CMP or renal profile
- CBC or H/H
- pulse oximetry or ABG
- CRP
- amylase level (Note: levels do NOT correlate with disease severity; failure to improve may indicate local complication, e.g. necrosis or infection; > 2-3 levels rarely necessary)

Initial Management Principles, ALL patients:

- effective pain control: parenteral narcotic analgesics, preferrably by PCA mode,recommended (morphine should be avoided due to risk of increased sphincter of Oddi pressure)
- adequate fluid resuscitation: goal = normal hemodynamics (SBP ≥ 90, HR < 100) & urine output ≥ 0.5 cc/kg/hr **w/in 12 hr**. **of presentation**
- NPO except sips H2O for po meds (NG tube NOT recommended unless persistent N/V or ileus)
- lipase level prior to re-feeding (daily level NOT recommended due to long half-life)
- consider nutritional support if NPO ≥ 7 days or severely nutritionally depleted on admission

Additional Management Principles

Mild Pancreatitis (~80% all cases; < 5% deaths)

ALL Patients (Gallstone & Non-Gallstone)

Recommended:

- admit to general med/surg ward
- re-feed when pain subsided, pancreatic enzyme levels improved (do NOT need normal levels but literature shows pain relapse more likely if lipase still >3x nl when pt re-fed); lo-fat, hi-carb. diet w/ small meals preferred

NOT Recommended:

- **routine** use of antibiotics, H2 blocker/PPI, ERCP, or CT scan (consider CT if signs clinical deterioration)

Gallstone Pancreatitis Patients

- **surgery consult**: cholecystectomy w/ intra-op cholangiogram recommended prior to hospital d/c
- consider GI consult, esp. if LFT's elevated, dilated CBD , signs of cholangitis, or failure to improve clinically
- IV antibiotics if CBD obstructed

Non-Gallstone Pancreatitis Patients

- consider GI consult, esp. if h/o recurrent idiopathic pancreatitis (microlithiasis likely)

Severe Pancreatitis (~20% all cases; > 95% deaths)

ALL Patients (Gallstone & Non-Gallstone)

Recommended:

- admit to ICU or intermediate unit
- consider central line, CVP monitor & H2 blocker/PPI
- CT scan of pancreas on **≥ day 3** to R/O necrosis & determine CT Severity Index (see "Definitions in Acute Pancreatitis")
- In pts w/ necrosis on CT:
  - CT-guided aspiration & biopsy to R/O infected necrosis (**surgery consult** if present)
  - IV antibiotics (agent w/ broad-spectrum aerobic & anaerobic coverage preferred, e.g. imipenem/meropenem; literature suggests lower rate septic complications in this subset of pts)
- GI consult

Gallstone Pancreatitis Patients

- **GI consult** to consider ERCP (literature shows decreased morbidity w/ early ERCP in this subset); urgent if increasing LFT's or signs of cholangitis
- **surgery consult** to determine timing of cholecystectomy
- IV antibiotics if CBD obstructed

11/07/2002