GI V: Pancreas & Biliary Tract Cheat Sheet

by kselIybelly via cheatography.com/19318/cs/2436/

Acute pancreatitis

Etiology

Cholelithiasis & EtOH (most common), can also be hyperlipidemia, trauma, drugs, hypercalcemia, penetrating PUD, antiretroviral HIV meds

Clinical Presentation

Ranges from mild episodes of deep epigastric pain w/ N/V to the sudden onset of severe pain with shock

Clinical Features

Epigastric pain radiating to the back, improves with leaning forward or lying in fetal position, N/V, fever, leukocytosis,sterile peritonitis

Indicators of a Poor Prognosis

Severe hypovolemia, ARDS, tachycardia > 130bpm

Lab Studies

Elevated serum amylase, lipase, WBC, LFTs if biliary obstruction, Ranson's criteria = poor prognosis

Treatment

NPO (to prevent secretion of pancreatic juices), restore and maintain fluid volume, and start parenteral hyperalimentation

Pain Management & Monitoring

Meperidine +/- abx. Monitor pt. for complications (pancreatic pseudocyst, renal failure, pleural effusion, hypocalcemia, pancreatic abscess)

Choledolithiasis

Definition

Gallstones

Treatment

Only treat the complications, because most people with gallstones never develop the disease

Complications

Cholecystitis, pancreatitis, acute cholangitis

Primary Sclerosing Cholangitis

Definition

A chronic thickening of the bile duct walls of unknown etiology (but 80% of cases are associated with IBD, specifically ulcerative colitis)

Strongly associated with

Cholangiocarcinoma + increased risk of pancreatic and colorectal carcinoma

Typical patient

M>>F, mean age 39

Clinical Presentation

Jaundice + pruritis (also fatigue malaise, weight loss), hepatomegaly, splenomegaly

Treatment

Ursodiol + endoscopic management of stricture

Only treatment with a known survival benefit

Liver transplant

Chronic Pancreatitis

Etiology

EtOH (almost 90% of cases, can also be from gallstones, PUD, etc.)

Clinical Features

Epigastric pain radiating to the back, improves with leaning forward or fetal position, N/V, + fat malabsorption steatorrhea later in disease

Classic Triad

Pancreatic calcifications, steatorrhea, diabetes mellitus

Lab Studies

Amylase level elevated early in disease, abdominal plain film radiography shows calcification in 20-30% of pts

Lab Studies

Amylase level elevated early in disease, abdominal plain film radiography shows calcification in 20-30% of pts

Treatment

Address underlying cause (EtOH), NPO, fluid volume restoration, parenteral hyperalimentation, low-fat diet upon discharge. Surgical removal for pain control.

Acute Cholecystitis

Definition

Caused by obstruction of the bile duct (usually by a gallstone) leading to chronic inflammation

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Acute Cholecystitis (cont)

Clinical Presentation

> Colicky epigastric or RUQ pain, becomes steady and increases in intensity. Often happens after a fatty meal, ?right shoulder/subscapular pain, N/V, low-grade fever, constipation, mild paralytic ileus

Lab Findings

> Bilirubin levels increase in blood and urine after 24 hours, leukocytosis, gallstones, HIDA, ERCP

Treatment

> Surgery (cholecystectomy)

Pancreatic Neoplasm

General

> 5th leading cause of cancer death in US

Risk Factors

> Older age, obesity, tobacco, chronic pancreatitis, previous abdominal radiation, family history

Clinical Presentation

> Abdominal pain +/- radiating pain, jaundice, palpable gallbladder (Courvoisier's sign) if cancer of pancreatic head

Diagnostic Studies

> CT to delineate disease and look for mets, angiography to look for vascular invasion

Treatment

> Surgical resection (modified Whipple's procedure) if no mets, ?subsequent radiation/chemo. Poor prognosis.

Acute Cholangitis

Definition

> Potentially deadly condition of common bile duct obstruction combined with ascending infection (most commonly caused by *E. coli, Enterococcus, Klebseille, Enterobacter* --> can lead to sepsis and death

Etiology

> Most often caused by choledocholithiasis

Clinical Presentation

> RUQ tenderness + jaundice + fever (Charcot's Triad), +/- AMS & hypotension (Reynold's pentad)

Lab Findings

> RUQ U/S shows biliary dilation or stones, good initial test. Leukocytosis + left shift, increased bilirubin, increased LFTs. ERCP best for dx + tx of stable pt (unless urgent compression necessary)

Treatment

> Antibiotics (fluroquinolone, ampicillin, gentamycin +/- metronidazole), fluid & electrolytes, analgesia. ERCP for stable patiends. Cholecystectomy after acute syndrome resovled when there is choledocholilithiasis

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