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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