

### 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)

### Cholelithiasis

#### 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

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#### 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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Page 1 of 2.

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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*, *Klebsiella*, *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 patients. Cholecystectomy after acute syndrome resolved when there is choledocholithiasis



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