



AAST Acute Care Surgery Didactic Curriculum

Pancreatitis

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Highlights:

- Patients with acute pancreatitis should have an ultrasound on admission or within 48 hours. CT is the imaging modality of choice and though it is not required, can help to clarify uncertain diagnosis, and/or reveal hemorrhage. Necrosis/ischemia may not be evident within the first 7 days of disease.
- An intervention should be performed when a diagnosis or suspicion of infected pancreatic necrosis is refractory to medical management and/or when there is continued clinical deterioration. This is preferentially performed once the necrosis is walled off, roughly 4 weeks after disease onset. Percutaneous drainage is first line of treatment and can either avoid operative intervention entirely or delay an operative intervention to a more favorable time.
- Surgical intervention should be considered in the continuum of a step-up approach after percutaneous/endoscopic drainage, in cases of refractory bleeding, as management of abdominal compartment syndrome, in the setting of concomitant bowel ischemia, acute necrotizing cholecystitis, or bowel fistula to the peripancreatic collection.
- Minimally invasive techniques such as VARDS or transgastric endoscopic necrosectomy require more interventions, but result in less post-operative new-onset organ failure. There is insufficient data on the mortality comparison between open, minimally invasive, or endoscopic necrosectomy techniques.
- After open necrosectomy, goals should be source control, bowel viability, early fascial closure and/or definitive abdominal closure. Closure is more successful and lessens complications if done earlier vs later.
- There is no consensus on routine ERCP in the management of predicted severe acute pancreatitis.