ACUTE PANCREATITIS

Diagnose · resuscitate moderately · treat the cause

MODERATE
fluids

DIAGNOSE *2 of 3*

- **Pain -** epigastric, radiating to the back
- **Enzymes -** lipase (or amylase) > 3 × upper limit of normal
- **Imaging -** characteristic findings on CT / MRI / ultrasound
- **Then -** any 2 of these 3 confirms it - do not wait for CT

ASSESS SEVERITY *predict + reassess*

- **Scores -** BISAP, APACHE-II, Ranson; CRP > 150 at 48 h
- **Red flags -** organ failure (Marshall), persistent SIRS, rising urea / haematocrit
- **Revised Atlanta -** mild · moderately severe · severe (persistent organ failure > 48 h)
- **CT for necrosis -** best after 72 h; earlier CT under-reads necrosis

MANAGEMENT · THE FIRST 24-48 H

supportive care is the treatment

MODERATE FLUIDS

Lactated Ringer's, goal-directed (WATERFALL): ~1.5 mL/kg/h, bolus 10 mL/kg only if hypovolaemic. Aggressive fluids cause overload.

ANALGESIA + FEED

Opioid analgesia (multimodal). Start early enteral / oral feeding as tolerated; nil-by-mouth is NOT required.

NO ROUTINE ANTIBIOTICS

Antibiotics only for infected necrosis or cholangitis - not prophylaxis. Monitor for infected necrosis (deterioration, gas on CT).

TREAT THE CAUSE

- **Gallstones (commonest) -** urgent ERCP if cholangitis / obstruction; cholecystectomy same admission (mild)
- **Alcohol -** withdrawal management, thiamine, counselling
- **Hypertriglyceridaemia -** > 11 mmol/L: insulin infusion ± apheresis; fibrate
- **Other -** drugs, hypercalcaemia, ERCP, autoimmune, trauma

COMPLICATIONS

- Local: necrosis, pseudocyst, walled-off necrosis, infected necrosis
- Systemic: SIRS, ARDS, AKI, shock, abdominal compartment syndrome
- Infected necrosis: step-up (drain → minimally invasive), delay surgery > 4 weeks
- Do not intervene on sterile necrosis unless symptomatic

MONITOR · ICU · NUTRITION

ESCALATE TO HDU / ICU

Persistent organ failure, severe pancreatitis, elderly / comorbid, or high fluid needs.

MONITOR

Urine output, lactate, glucose, calcium and intra-abdominal pressure (compartment syndrome).

NUTRITION

Early enteral / oral feeding; NG or NJ tube if not tolerating; avoid TPN unless enteral fails.

IMAGE & TIMELINE: resuscitate the first 24-48 h, reassess severity at 48 h. Contrast CT at 72 h+ to read necrosis. Infected necrosis (deterioration / gas on CT) → antibiotics + step-up drainage, delay definitive surgery beyond 4 weeks.

PEARLS & PITFALLS

- Moderate, goal-directed fluids (WATERFALL) - aggressive resuscitation causes overload and worse outcomes.
- No prophylactic antibiotics - reserve them for infected necrosis or cholangitis.
- Feed early: enteral nutrition beats nil-by-mouth and lowers infection; do not routinely keep them starved.
- Gallstone pancreatitis with cholangitis needs urgent ERCP; otherwise same-admission cholecystectomy.

References: ACG Acute Pancreatitis 2013 · WATERFALL, NEJM 2022 · IAP/APA · Revised Atlanta 2012.

Educational aid; verify doses against local protocol and patient factors.