

### Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/gi-insights/a-look-at-the-diagnosis-treatment-of-acute-pancreatitis/14233/>

### ReachMD

www.reachmd.com  
info@reachmd.com  
(866) 423-7849

---

## A Look at the Diagnosis & Treatment of Acute Pancreatitis

### Dr. Buch:

Acute pancreatitis remains the leading cause of inpatient care among gastrointestinal conditions. What do we need to know about the diagnosis and treatment?

You're listening to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. And today we are joined by Dr. Daniel Strand to share management updates for patients with recurrent acute and chronic pancreatitis. Dr. Strand is the Director of Pancreatobiliary Endoscopy at UVA Health in Charlottesville and an Associate Professor of GI Hepatology. He's also the lead author of "ADA Clinical Practice Update on the Endoscopic Approach to Recurrent Acute and Chronic Pancreatitis: Expert Review," which was published in *Gastroenterology* in 2022.

Welcome to the program, Dr. Strand.

### Dr. Strand:

It's fantastic to be here. Thanks for having me.

### Dr. Buch:

Dr. Strand, let's begin with an overview. Why is this expert review important?

### Dr. Strand:

So first I would just say, what a great opportunity it was to work with Dr. Law, Dr. Elmunzer, and Dr. Yang on this project, and through the AGA, and I said the whole process was absolutely fantastic. You know, my colleagues and I were asked to come up with eight best practice advice statements, for the AGA directed at endoscopic management of both recurrent acute and chronic pancreatitis, and I would just say that despite considerable interest in both of these subjects and dozens and dozens of publications, the overall quality standard and state of the literature is strikingly limited. There are very few high-quality prospective trials on any of these specific subjects, and both of these disease states are extremely heterogeneous and pretty difficult to study in an effective way. And so I think with that backdrop. It's pretty important to try to cautiously and thoughtfully synthesize what's out there and to give advice about practice in a meaningful way without overstating maybe some of the habits, and tendencies of my colleagues and I.

### Dr. Buch:

Now, if we dive into diagnostic updates, how do MR cholangiopancreatography and endoscopic ultrasound compare when it comes to diagnosing unexplained acute pancreatitis?

### Dr. Strand:

So, as you probably know, an inability to explain the etiology of pancreatitis persists in about a quarter of patients after a typical workup. And for the sake of clarity, I would just say that what that means is a good clinical history and physical basic lab testing including triglycerides and calcium liver chemistries and a right upper quadrant ultrasound. So, once a clinician gets to that point, I think it's common for more extensive or invasive testing to be considered, and there's a wide armamentarium of choices. It includes genetic testing, IgG-4 serologies, which are both intriguing in their own right, but more often, the next recommended test has been for further pancreas-specific imaging.

Now, both EUS and MRI with MRCP have been used for this purpose, and I would say that actually they have both been studied fairly extensively. Of the two, there are several direct comparisons, and when directly compared, EUS has been shown to demonstrate a potential cause for acute pancreatitis much more often than MRI. I think a recent meta-analysis actually showed an odds ratio of about 3.5 favoring EUS over MRI. Now, this observed difference led my co-authors and I to suggest EUS should be the next preferred

diagnostic test for unexplained pancreatitis after an inconclusive initial workup. Having said that though, there are a few caveats built into that. So first I would just offer that the sensitivity of EUS, for previously unknown explanation for pancreatitis is extremely variable throughout the literature. It ranges from 30 to 90 percent depending upon the context. It's also an invasive test, whereas MRI is an entirely noninvasive one. And so, while we suggest that EUS be the next test in the algorithm when evaluating patients with unexplained acute pancreatitis, MRI can often be useful and complementary, and so it is not uncommon for patients to wind up having both done at some point depending upon local experience and availability.

**Dr. Buch:**

Thank you for that. And as a quick follow-up to that, when is the optimal time to perform an endoscopic ultrasound for a patient with unexplained acute pancreatitis?

**Dr. Strand:**

Actually, I appreciate this question very much. It's an incisive one and you've identified an area that my co-authors and I spent a fair amount of time discussing amongst ourselves. We actually did a pretty extensive literature review on this question during manuscript development and to try to critically appraise our own practices, and ultimately, there isn't very much out there to guide us. Now, I didn't mention this before, but one of the reasons why further imaging is important in the setting of unexplained recurrent acute pancreatitis is that a proportion of patients will actually have an underlying malignancy. The likelihood of finding a cancer varies depending on circumstances but can be in the range of 5 to 12 percent, which is not negligible. Assessing the pancreas by EUS in the middle of an inflammatory episode, particularly one with a local complication like necrosis can really affect image quality, and none of the parenchymas may look as expected and may significantly bias the endoscopist. So, in concept, allowing the pancreas to calm down and return closer to its baseline should allow for better exams and more accuracy, but how much time is the right amount? I think that piece is really unclear. But if you ask me what my colleagues and I do, I would say that we typically wait between two and six weeks after the initial injury to perform EUS.

**Dr. Buch:**

Very useful information. Thinking about recurrent acute pancreatitis, what can you tell us about minor papilla therapy?

**Dr. Strand:**

So the first thing I would say on this subject is "stay tuned" because there's currently a prospective randomized controlled trial in recruitment that will hopefully answer the question regarding minor papilla intervention more definitively, although we may be a couple of years away from that answer.

So, what I would say is that until we have additional higher-quality data, it's been typical practice of my co-authors and I to offer minor papillary intervention to suitable patients, particularly in those who have signs of outflow obstruction, although, you know, that should occur after really thoughtful discussion of the associated risks because they're not trivial.

**Dr. Buch:**

Key message: Take those risks into consideration.

For those just tuning in, you're listening to *GI insights* on ReachMD. I'm Dr. Peter Buch, and I'm discussing endoscopic therapies for acute and chronic pancreatitis with Dr. Daniel Strand.

Now let's shift gears from diagnosis to treatment, Dr. Strand. Once a patient has been diagnosed with painful obstructive chronic pancreatitis, how do you choose between endoscopic therapy and surgery?

**Dr. Strand:**

Well, this is an excellent question. And so I would say with respect to symptomatic chronic pancreatitis as both a gastroenterologist and a therapeutic endoscopist, I think we tend to often bias endoscopic treatment over surgery.

The current state of the literature actually favors surgical intervention for obstructive chronic pancreatitis. We now have actually three prospective randomized controlled trials that suggest that surgery has superior outcomes in terms of both partial, and complete pain relief, as compared to endoscopy. And pain is the primary indication for intervention in these patients. Surgery, be it resection or decompression, is also a one-time affair. And by that, I mean ERCP for chronic obstructive pancreatitis is often repetitive and requires several procedures over a course of 12 to 18 months. And there are some stent-dependent patients out there, where endoscopy at prespecified intervals may be open-ended in nature. As an aside, it's actually intriguing to me that all three of these randomized controlled trials were performed in Europe and the most recent ESGE guideline favors or continues to favor endoscopy, over surgery.

And so, at the end of the day, I think the practice of medicine does involve individual patients, however, and surgical intervention is not right for everybody, but we should acknowledge our cognitive bias on this question. And my co-authors and I suggested surgery at least

be considered in each patient who presents with painful obstructive chronic pancreatitis.

**Dr. Buch:**

Thank you for that. And that leads us to an additional thought with regard to this. How often after surgery do patients still have abdominal pain?

**Dr. Strand:**

So the incidence of pain after surgery depends upon the individual randomized controlled trial, evaluated, but in general, patients, at five years after surgery, about 50 percent give or take will have complete or partial pain relief after surgery and that number is significantly lower in endoscopic trials. Sometimes it's in the 20 percent range. Sometimes it's in the 40 percent range just depending upon depending upon the study itself.

**Dr. Buch:**

Thank you for that further information. Dr. Strand, what can you tell us about endoscopic ultrasound-guided celiac plexus block pain relief in chronic pancreatitis?

**Dr. Strand:**

So you've identified another contentious subject, and to give you an example, my coauthors and I had four fairly different opinions about celiac plexus block, and there were four of us that worked on the CPU. So, what I would say is this. Pain in chronic pancreatitis is likely to be multifactorial and fairly complex.

Celiac plexus block represents a single intervention employed in the setting of likely all of these with expectedly mixed results. As an example, patients who have pancreatic cancer-related pain, celiac plexus block in neurolysis appears to work extraordinarily well. Patients with chronic pancreatitis, I would say the current state of the literature, suggests response rates that range between 50 and 60 percent. And all of that is from uncontrolled series. There is no, to my knowledge, existing placebo-controlled trial on celiac plexus block. That intervention is also limited by its short duration of action. It lasts only a few months. And almost all patients will require analgesics at some point after celiac plexus block. And so it's generally regarded as a safe procedure. There are also rare serious adverse events that can occur. And so it's not a risk-free endeavor. So I would say that general use of celiac plexus back for patients with symptomatic chronic pancreatitis is probably not advisable without more data, but that if you're extraordinarily selective for patients who have failed other interventions or for in whom things like surgery would be inappropriate, it is something at least to be considered carefully and thoughtfully.

**Dr. Buch:**

Finally, Dr. Strand, are there any other insights you'd like to share with our audience?

**Dr. Strand:**

So I would just say that management of both of these diseases, acute and chronic pancreatitis, whether endoscopically or otherwise is very complex. And again, I was fortunate to work on this with a phenomenal group of colleagues, and if anything, this exercise has underscored for me how much work there is to be done on the topic. Despite how common both acute and chronic pancreatitis are, and how heterogeneous these diseases are, each patient's clinical problem really can have some unique features, that make applying existing retrospective data really a challenge. It's made the state of the literature biased in a way that makes it difficult to know exactly what to do in each unique circumstance, and so, what I would say is that despite the challenge I do see an opportunity in the future to try to incorporate some well-designed prospective comparative studies, in pancreatitis care with a goal of developing more unified diagnostic and therapeutic pathways for these patients.

**Dr. Buch:**

As we come to a close, I'd like to thank my guest, Dr. Daniel Strand, for joining us to discuss endoscopic approaches to recurrent acute and chronic pancreatitis.

Dr. Strand, it was a pleasure having you on the program.

**Dr. Strand:**

My pleasure. It's great to be here.

**Dr. Buch:**

For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit [ReachMD.com/GIInsights](https://ReachMD.com/GIInsights) where you can be Part of the Knowledge. Thanks for listening, and see you next time.