Acute Biliary Pancreatitis
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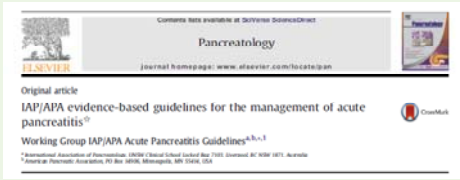

Pancreatology

journal homepage: www.elsevier.com/locate/pan

Original article

IAP/APA evidence-based guidelines for the management of acute pancreatitis

Working Group IAP/APA Acute Pancreatitis Guidelines

Acute biliary pancreatitis
Case 1

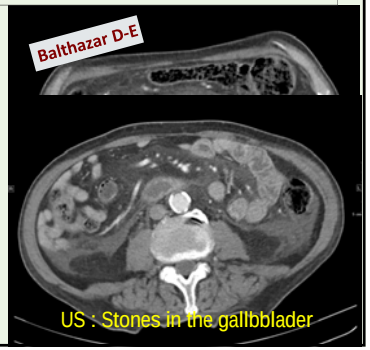
Past history
- Ischemic cardiopathy (stents; coronary artery by-pass)
- Arterial hypertension
- Diabetes type 2
- Esophagitis (reflux)

aspirin ; glicazide, metformine ; bisoprolol, eprosartan, simvastatine ; pantoprazole

- Suddent epigastric pain (< 24 h)
- Dyspnea
- -19 Kg < 9 months
- No alcohol
- Physical examination :
  - Upper abdomen tenderness
  - Pulse : 90/M ; AP : 14/9

Acute biliary pancreatitis
Case 1

Biology :
- HB : 15.7
- WBC : 9.950
- CRP : 31 mg/l
- Lipase : 3970
- Bili : 9,2
- GPT : 89
- A.P. : 193
- Creat : 1.7



Q8 Whats the more precise diagnosis?

A. Mild acute biliary pancreatitis
B. Moderately severe acute biliary pancreatitis
C. Predicted severe acute biliary pancreatitis
D. Severe acute biliary pancreatitis

Question 8

25% 1. Answer A
25% 2. Answer B
25% 3. Answer C
25% 4. Answer D

10

Revision of Atlanta's Classifications for Acute Pancreatitis

- Mild acute
  - No organ failure
  - No complication
- Moderately severe
  - No (or transient) organ failure (>48h)
  - Local complications
- Severe
  - Persistent organ failure (>48h)
- ***Predicted severe***

P Banks et al Gut 2012

Q9. What's the next examination do you will perform?

A. EUS
B. MRCP
C. ERCP
D. 1 or 2

Question 9

25% 1. Answer A
25% 2. Answer B
25% 3. Answer C
25% 4. Answer D

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Acute biliary pancreatitis

EUS (> MRCP, *[G 2C]*) prevent unusefull ERCP

- Persistant liver tests elevation
- Dilation of CBD

} (without cholangitis)

- ERCP impossible or technically challenging, ex :
  - Pregnancy
  - Gastric surgery…
- ***NO ERCP***
  - Mild pancreatitis without cholangitis *(G 1A)*
  - Improvment of liver tests
  - No stone on CBD (EUS or MRCP)

Acute biliary pancreatitis

Case 1

EUS
- Papilla not seen (diverticula)
- Wirsung not dilated ; heterogenous pancreatic parenchyma
- Stone in common bile duct and severe cholangitis

Biology (24 h)
- HB : 13.7
- WBC : 11.980
- CRP : 89 mg/l
- Lipase : 854
- Bili : 13.7
- GPT : 51
- A.P. : 308
- Creat : 1.9

Q 10. Why do you do ERCP in this patient?

A. Persistent obstruction of BCD
B. Persistent pain
C. Cholangitis
D. Predicted severe pancreatitis

Question 10

25% 1. Answer A
25% 2. Answer B
25% 3. Answer C
25% 4. Answer D

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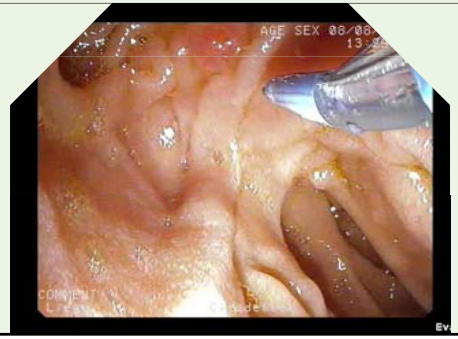
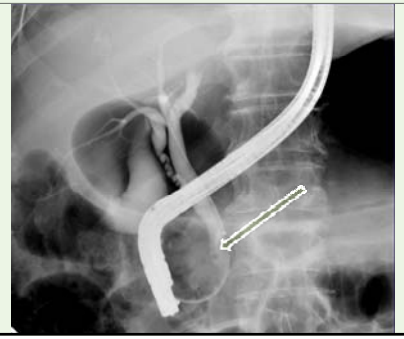
Acute biliary pancreatitis
Indication of ERCP with papillotomy

- A. Persitent obstruction of CBD *[G 1C]*
- B. Persistent pain : no
- C. Cholangitis *[G 1B]*
- D. Predicted severe pancreatitis :
- E. A+D

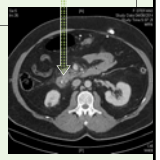
Acute biliary pancreatitis
Case 1 : ERCP - Papillotomy



Acute biliary pancreatitis
Case 1



When do we perform papillotomy for ABP ?



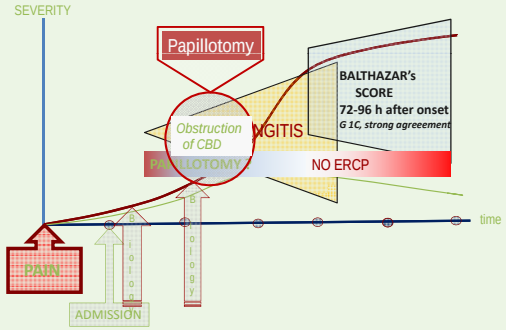
- **Acute cholangitis** *[G 1B, strong agreement]*
- Early in the course (24 h < admission)
- Stone in CBD (CT-EUS-MRCP, *[G 1C]*)
- Persitant obstruction without chonlangitis ?

IN ABP, URGENT ERCP IS CONTROVERSIAL

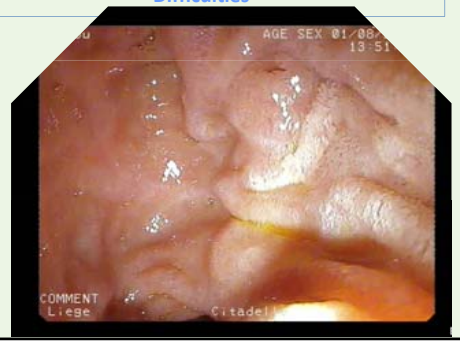
« ERCP did not lead to a significant reduction in the risk of overall complications and mortality »
Petrov MS et al, Ann Surg.2008; 247 (2): 250
Tse F. et al, CochranDatabase Syst Rev. 2012; 5: CD009779

« ERCP reduced pancreatitis-related complications but not mortality in patients predicted to have severe pancreatitis (no benefit for mild pancreatitis) »
Moretti A et al. Dig Liver Dis. 2008; 40 (5): 379

Papillotomy, evaluating severity of ABP

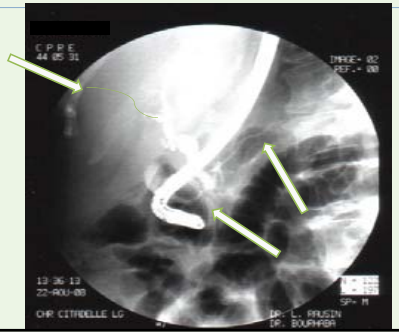


Acute biliary pancreatitis
Difficulties



Acute biliary pancreatitis

Papillotomy for edema and/or spasm of the papilla ?



Acute biliary pancreatitis

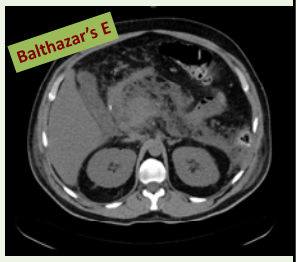
case 2

27/08 : Marroco

- Admission for acute biliary pancreatitis
- Renal function altered

04/09 : ICU

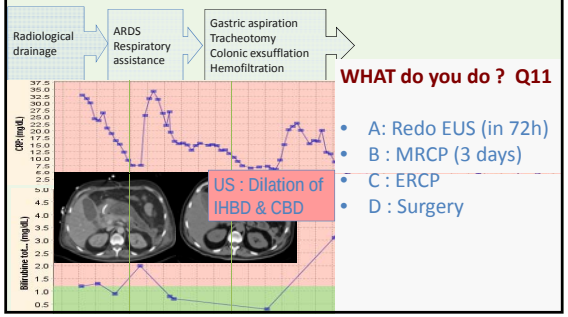
- Renal insufficiency
- CRP > 300 mg/l
- Imipenem



EUS : Severe pancreatitis. No stone seen but examination very difficult

Acute biliary pancreatitis

case 2 : question

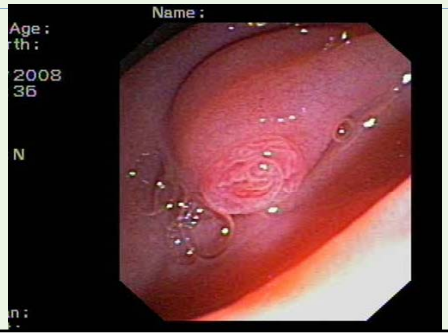


WHAT do you do ? Q11

- A: Redo EUS (in 72h)
- B : MRCP (3 days)
- C : ERCP
- D : Surgery

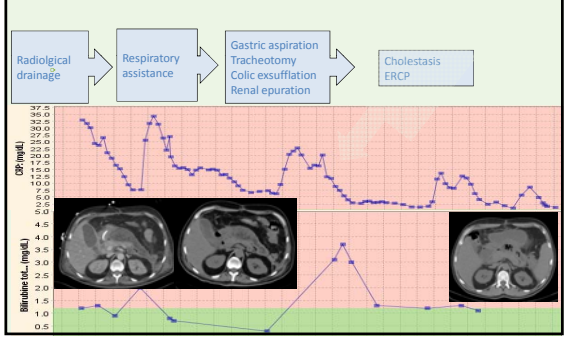
Acute biliary pancreatitis

case 2



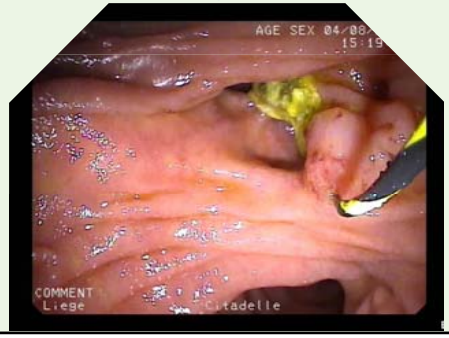
Acute biliary pancreatitis

case 2



Acute biliary pancreatitis

Difficulties for specific CBG cannulation



Acute biliary pancreatitis
case 3

Past history
- Arterial hypertension
- Diabetes
- Peptic ulcer disease with UGI bleeding 1990, endoscopical hemostasis

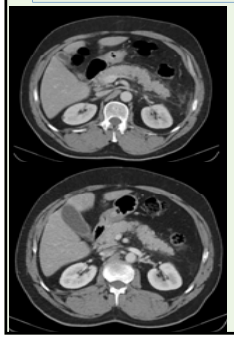
aspirin ; glicazyde, metformine ; valsartan, simvastatin.

- Sudden severe right upper abdmonal pain
- Fever 38,7 °C
- Puls : 120/M

Physical examination
- Epigastric tenderness
- Jaundice

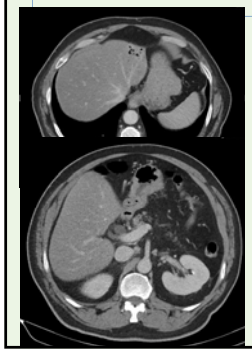
US : sludge, dilation IHBD

Acute biliary pancreatitis
case 3



Biology :
- HB : 12.4
- WBC : 14740
- CRP : 269 mg/l
- Bili : 33
- GPT : 246
- A.P. : 154
- Lipase : 210 (60)
- Blood C : E. Coli

Acute biliary pancreatitis
case 3



EUS :
- Dilation of CBD
- Sludge : CBD and gallblader
- No stone seen

Q11. Whats the most likely diagnosis?

- A: Mild acute biliary pancreatitis
- B : Other
- C : Cholangitis < biliary sludge, without pancreatitis
- D : Acute pancreatitis + cholangitis

Question 11

25% 1. Answer A
25% 2. Answer B
25% 3. Answer C
25% 4. Answer D

10

(wrong) Acute biliary pancreatitis
case 3