Chronic Pancreatitis

Description

Chronic inflammation which results in irreversible damage. Assoc with severe abdo pain and endocrine or exocrine dysfunction. Difficult illness to diagnose and manage.

Epidemiology / Pathophysiology

- 4M:1F and average onset is age 40y
- Exact aetiology unclear & how acute & chronic pancreatitis related
- Large duct (M>F, assoc with calcification & steatorrhoea) vs. small duct pancreatitis (F>M, no calcification & steatorrhoea rare, responds to pancreatic replacement)
- End result is pancreatic fibrosis which can take several years to develop.

Causes

- Alcohol (2/3 of cases)
- Biliary tract disease
- Trauma, incl. iatrogenic (ERCP)
- Metabolic e.g. hyperTG, hyperCa
- Congenital disorders e.g. CF
- Drugs: azathioprine, sulfonamides, loop diuretics
- Idiopathic
- Autoimmune pancreatitis
- Tropical pancreatitis
- Hereditary pancreatitis
- Abdominal radiotherapy

Presentation

- Episodic exacerbations with intervening remission or continuous pain in patients.
- Sev epigastric pain (→back), N&V, decreased appetite, exocrine dysfn (malabs→ wt loss, diarrhoea, steatorrhoea & protein deficiency), DM
- Examination often unremarkable apart from tenderness in the abdomen.

Investigations

Early diagnosis difficult as no biochemical markers exist and abdominal radiology may be NAD.
Bloods: FBC, UEC, LFTs, Ca^{2+}, amylase/lipase (usually normal), BSL, Hb_{a1C}.
Imaging: USS, CT, ERCP/MRCP even AXR may show pancreatic calcification.
Other: Secretin stimulation test (not routine), tests for malabs (serum trypsinogen, urinary d-xylose or faecal elastase). Pancreatic biopsy (rare)

Management

Specific

- Treat malabsorption: replacement of pancreatic enzymes (lipase). **Creon®**
- **Octreotide** (pancreatic enzyme secretion & CCK levels). **Proglumide** (CCK receptor antag).
- Treat Cx: cobalamin deficiency, drain effusions (pericardial, peritoneal, pleural), adenoCa

Supportive

- Analgesia: Simple analgesics ± opiates. ERCP dilatation. Nerve blocks (occ used)
- Dietary advice
- Counselling regarding EtOH, drug abuse, psychiatric conditions if appropriate

Surgical management

- Decompression of psuedocyst or a duct dilatation if failed ERCP
- Pain Mx: Thoracoscopic bilateral splanchinectomy, pancreatoduodenectomy, resection of the pancreatic head, extended lateral pancreaticojejunostomy.
- ?Pancreatectomy followed by autologous islet cell transplantation

Prognosis

- ↑Mortality and morbidity - ≥1/3 die in 10y