TUTORIALS

PG Residency
Gastroenterology & Hepatology

Smart Notes. Better Scores.

Acute Pancreatitis: Definition & Diagnosis

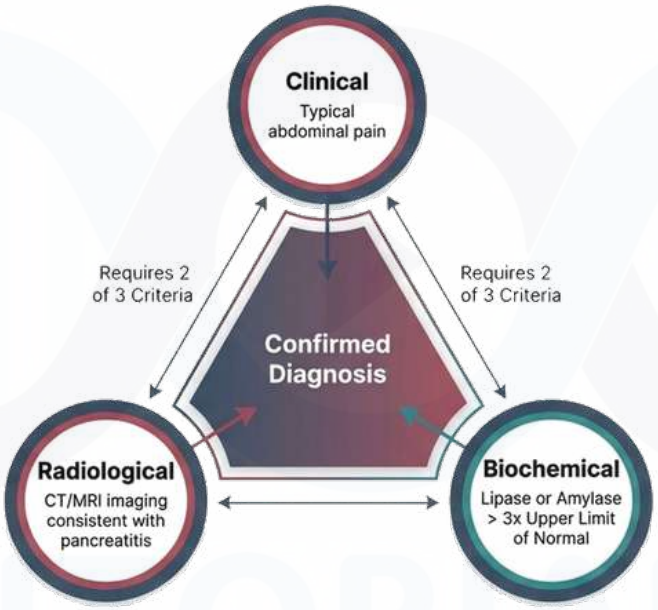
Clinicalconfirmationrequires2of3diagnosticcriteria.

Definition

- Pancreatic injury followed by acute inflammation.

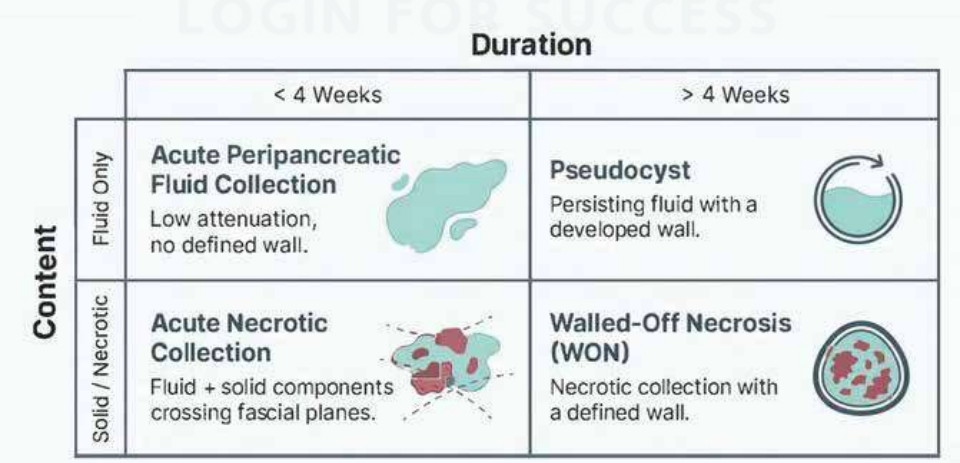
Diagnostic Rule

- Twoormoreof the three criteria (Clinical, Biochemical, Radiological) must be present for a confirmed diagnosis.



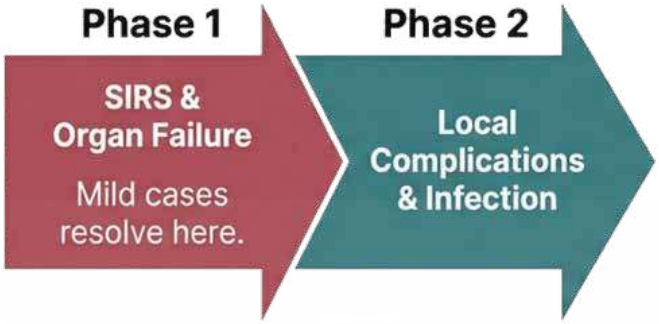
Terminology of Fluid Collections & Necrosis

Classificationbasedoncontenttypeanddurationofinjury(RevisedAtlanta Classification).



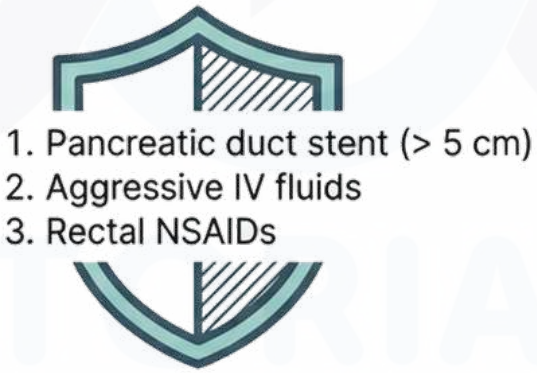
Phases, Etiology & Prevention

Understandingprogressionandmitigatingrisk.



Etiology

- Primary Causes: Gallstones & Alcohol
- Drug-Induced: Hypersensitivity reaction (onset 4-8 weeks, not dose-related). Exception: Steroids (dose-dependent).



Biochemical Investigations

ComparativeanalysisofAmylaseversusLipase.

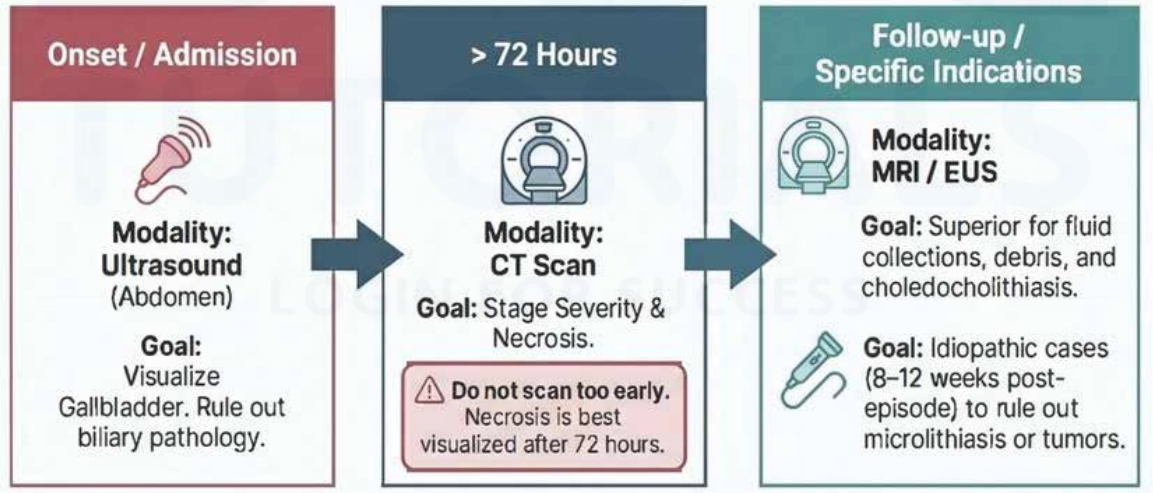
Serum Amylase	Serum Lipase {Preferred)
• SensitivityIssues:Falsenegatives in fatal attacks, mild cases, chronic pancreatitis, or hypertriglyceridemia. • False Positives: Salivary gland inflammation, renal failure (decreased clearance), macroamylasemia, gut perforation.	• Specificity: Superiortoamylase. Rarely >3x normal in non-pancreatic causes. • Prognostic Value: Levels > 2.5x prior to refeeding predict feeding intolerance. • Non-Pancreatic Elevation: Renal failure (usually <3x).

Clinical Pearl: Combining Amylase + Lipase does not improve diagnostic accuracy.

Note on Calcium:Hypocalcemia occurs due toextraction of albumin-rich intravascular fluid into the peritoneum.

Imaging Strategy & Timing

Selecting the right modality at the right time.



Severity Scoring & Prognosis

Validatedscoresandlabtrendspredictoutcomes better than enzymes.

The BISAP Score (0-5 Points)

Score≥3-4indicatesincreasedmortality risk.

- BUN > 25 mg/dl
- Impaired Mental Status
- SIRS Criteria Present
- Age> 60
- Pleural Effusion

SIRS Criteria

Presenceof2+ suggests potential organ failure.

- Pulse> 90
- Temp < 36°C or> 38°C

•WBC < 4k or > 12k

• RR > 20 or pC02 < 32

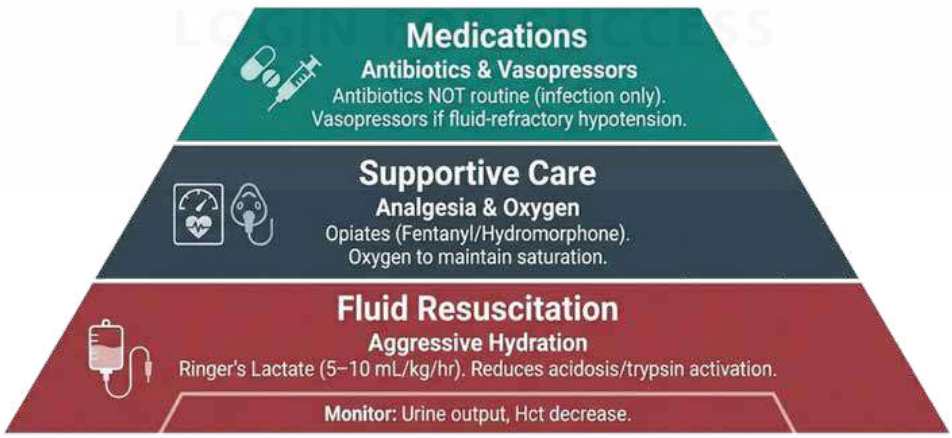
Red Flag Trends

Warning: Enzyme elevation height ≠ Severity.

- Rising Hematocrit (Hemoconcentration)
- Rising BUN / Creatinine
- CRP > 15 mg/dl at 48 hours

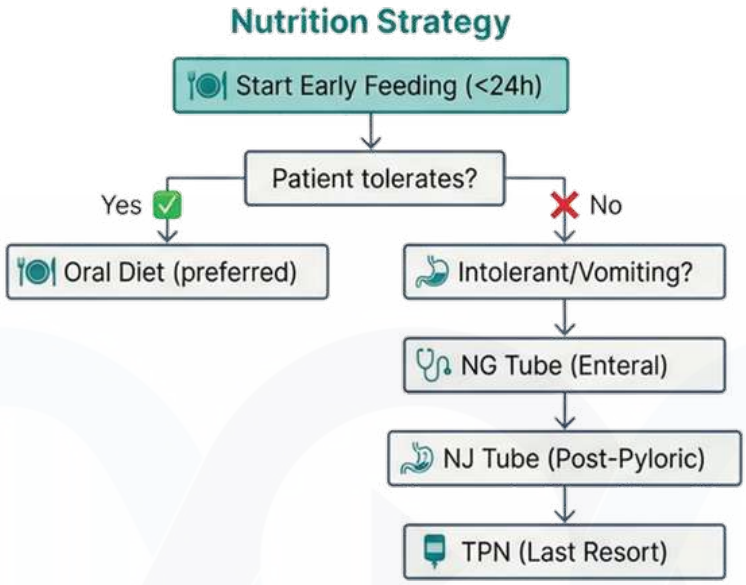
Initial Management

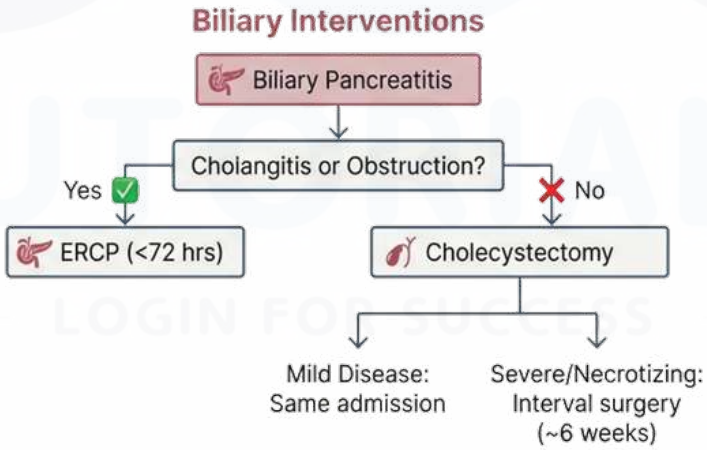
The"First24Hours"Protocol.



Nutrition & Interventions

Decisionlogicforfeedingandbiliarymanagement.

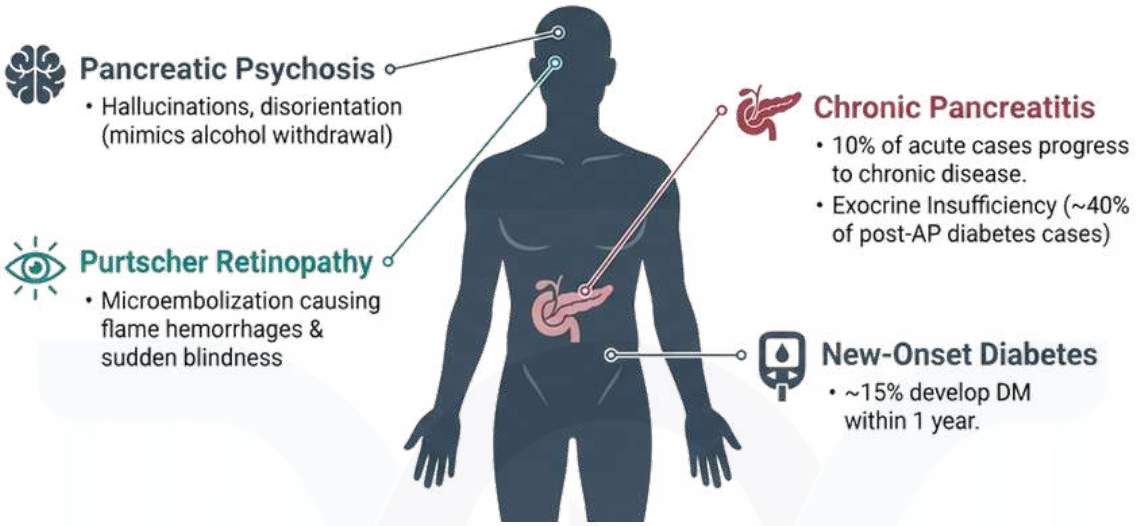




Drainage indicated for: Infected necrosis, obstruction, or disconnected duct syndrome.

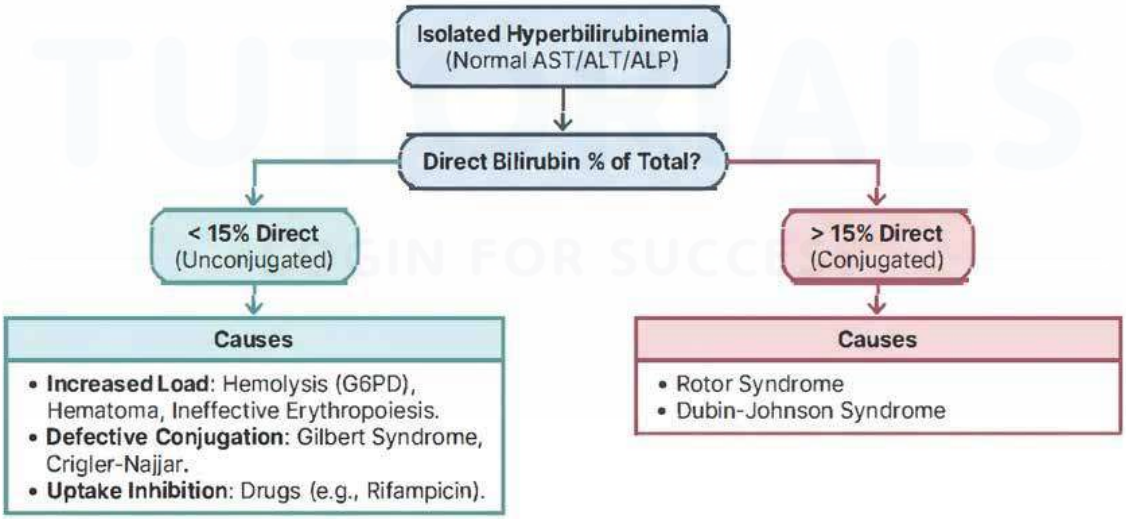
Complications & Sequelae

Systemicmanifestationsandlong-termoutcomes.



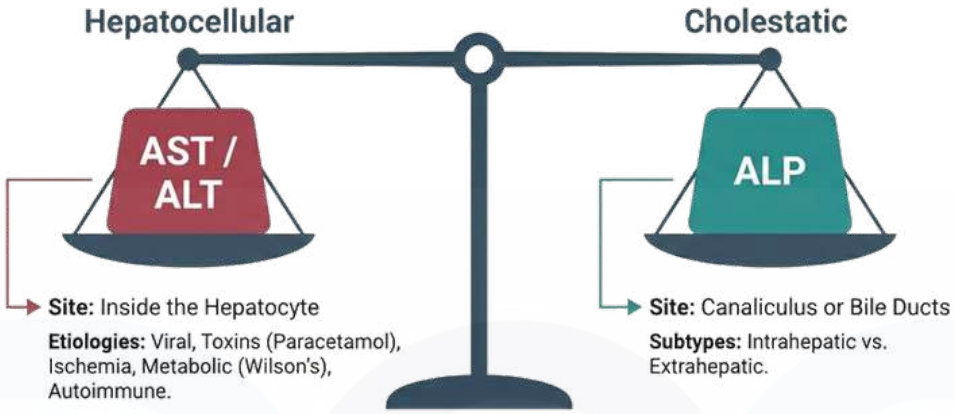
Approach to Jaundice: Isolated Hyperbilirubinemia

Evaluating jaundice with normal liverenzymes (ALT /ALP).



Hepatocellular vs. Cholestatic Injury

Distinguishing the primary site of injury.



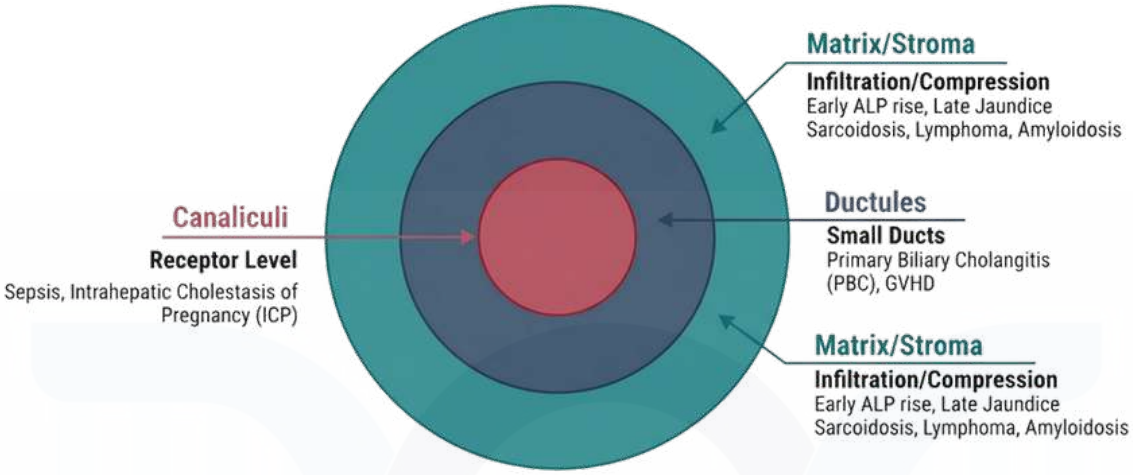
Extrahepatic vs. Intrahepatic Cholestasis

Differentiating obstruction from intrinsic liverdisease.

Extrahepatic (Obstruction)	Intrahepatic (Liver Disease)
Rule out first (Treatable). • Biliary surgery history, fever/pain (cholangitis), mass.	• Viral prodrome, hepatotoxins, portal hypertension.
Lab Key: INR normalizes with Vitamin K.	**Lab Key:** INR may NOT correct with Vitamin K.
• **Causes:** Stones, Strictures (PSC), Cancer.	• **Causes:** Viral, Drug-induced, Genetic.
Diagnostic: Imaging (US/MRCP).	**Diagnostic:** Biopsy / Serology.

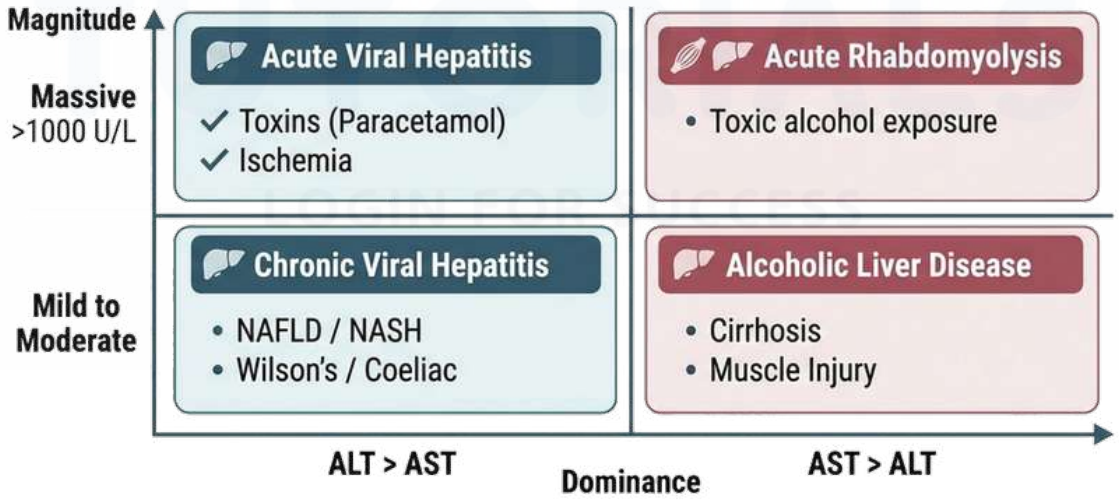
Intrahepatic Cholestasis: Levels of Injury

Anatomical localization of pathology



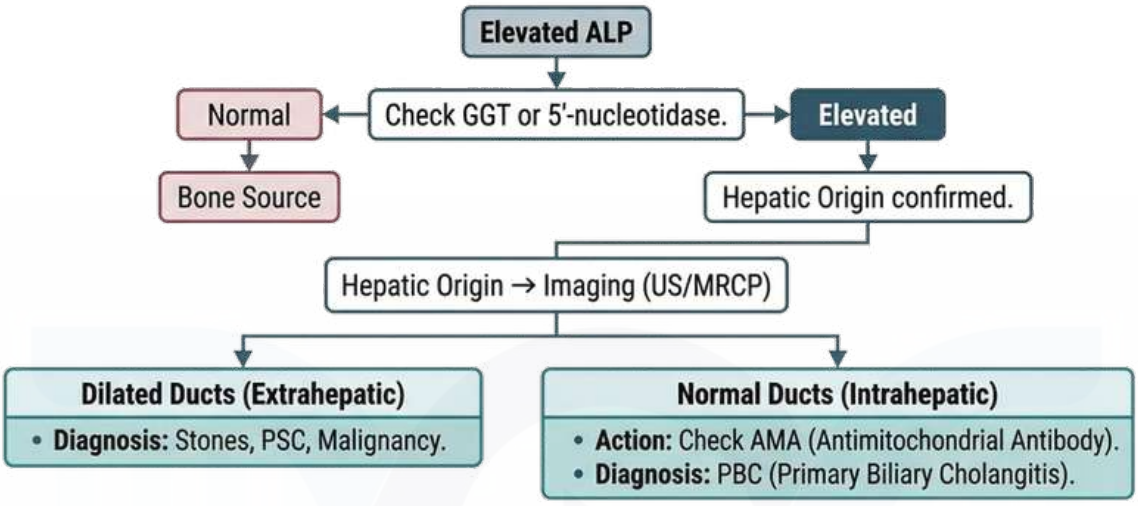
Evaluation of AST & ALT Patterns

Etiology based on Ratio and Magnitude.



Evaluation of Elevated Alkaline Phosphatase

Stepwise approach to confirm origin and etiology.



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