# key points

SELECTED BY

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**Chronic pancreatitis is a progressive inflammatory** condition characterised by irreversible fibrosis of the pancreatic parenchyma, accompanied by calcification and dilatation of the main pancreatic duct and its branches. There are multiple aetiologies including excessive alcohol consumption, smoking, autoimmune disease and post acute severe pancreatitis. However, excessive alcohol consumption is the most common cause.

**The prevalence of chronic pancreatitis is variable, with** estimates between 4 and 52.4 per 100,000. A mismatch exists between reported incidence and prevalence in many studies suggesting chronic pancreatitis is under recognised. One cause for this mismatch is that once diagnosed many patients are lost to secondary care follow-up. Therefore, although a GP may only see two new cases during their career they are likely to encounter patients requiring recurrent consultations.

**Chronic pancreatitis presents with relapsing, remitting** upper abdominal pain accompanied by features of malabsorption and malnutrition due to pancreatic exocrine insufficiency and diabetes due to endocrine deficiency. Diabetes is more likely to occur as the duration of chronic pancreatitis increases, where pancreatic exocrine insufficiency has developed after pancreatic resection and in those with early onset calcification.

**Patients with suspected chronic pancreatitis should be** referred to gastroenterology or a specialist pancreatic centre for confirmation of the diagnosis. Providing there is no need for urgent admission or referral, NICE recommends that GPs should arrange blood tests and abdominal ultrasound to exclude other conditions such as gallstones. In secondary care, CT is the preferred diagnostic investigation especially if there is a history of alcohol misuse. Faecal elastase-1 is the first-line investigation for screening for pancreatic exocrine insufficiency.

**Complete abstinence from alcohol and smoking** cessation is essential for all patients to slow disease progression and improve pain. Patients with evidence of malnutrition, malabsorption or pancreatic exocrine insufficiency should be treated with pancreatic enzyme replacement therapy to improve symptoms, nutritional status and quality of life.

**Initially pain should be managed by prescribing simple** analgesia with the addition of a weak opioid if necessary. Adjuncts such as gabapentin and tricyclic antidepressants have been shown to be beneficial. Care should be taken when prescribing to avoid polypharmacy and opioid dependence. Strong opioid prescribing should be avoided in primary care if possible but, if considered, it should prompt a referral to secondary care to review alternatives. Uncontrolled pain should trigger referral to secondary care for multidisciplinary assessment by physicians, surgeons and specialist pain clinics.