key points

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Acute pancreatitis is characterised by inflammation of the exocrine pancreas in association with a local and systemic inflammatory response. Early recognition, prompt referral to secondary care and close monitoring for complications is important in improving outcomes in acute pancreatitis. Gallstones followed by excessive alcohol consumption account for around 75% of cases in the UK.

The diagnosis of acute pancreatitis should be considered in any patient presenting with abdominal pain. History and examination can be indicative of the diagnosis; however, two out of the following three diagnostic criteria should be met: typical history; elevated serum amylase or lipase (> 3 ULN); imaging (ultrasound, CT or MRI) consistent with acute pancreatitis. The most common pattern of pain is severe epigastric pain that radiates to the back, is exacerbated by movement, and is alleviated by sitting forwards. Patients may appear agitated, distressed or confused. They may give a history of anorexia, nausea, vomiting and reduced oral intake. All patients with clinical findings suggestive of acute pancreatitis should be referred for urgent evaluation.

Gallstone pancreatitis is seen most commonly in patients with gallbladder disease, typically women over the age of 60, while alcoholic pancreatitis is seen more frequently in men, and generally at a younger age than those with gallstone pancreatitis. Elevated ALT at presentation suggests a likely biliary origin, with a level ≥ 150 IU/L having a positive predictive value of 85% in predicting a gallstone aetiology.

Amylase remains the test of choice for acute pancreatitis. Elevated levels of serum amylase or lipase (> 3 ULN) support, but are not pathognomic for, a diagnosis of acute pancreatitis. The diagnostic performance of these tests decreases in the hours and days after the onset of acute pancreatitis, and so additional investigations should be performed if there is suspicion of missed or established acute pancreatitis. Early and serial CRP testing is used as an indicator of severity and progression of inflammation.

Local complications include pancreatic necrosis and pancreatic collections. These complications may present both during the acute episode and to GPs after an episode of 'missed' pancreatitis, or following hospital discharge. Upper abdominal pain, bloating, early satiety, nausea, vomiting and signs of infection including pyrexia, sweats and tachycardia are common presentations of these complications. Mild acute pancreatitis generally resolves and leaves pancreatic function intact, although many patients progress to recurrent acute pancreatitis or chronic pancreatitis. Late complications are often permanent and classically relate to pancreatic destruction. Exocrine insufficiency is a common consequence of severe disease that will result in severe nutritional deficiencies if not addressed by an experienced multidisciplinary team. NICE recommends six monthly HbA_{1c} measurement and bone mineral density assessments every two years, in order to monitor for the development of diabetes and osteopenia/osteoporosis.