key points

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In chronic pancreatitis chronic inflammation of the pancreas results in irreversible injury and fibrosis. This leads to local and systemic complications. The annual incidence in Europe is estimated to be 6-7 per 100,000 population. Mortality rates in patients with chronic pancreatitis are five-fold greater than in the general population. The most common causal factor is excess alcohol consumption, estimated to be responsible for 45-84% of cases. However, it is important not to assume that chronic pancreatitis is alcohol-related just because the patient drinks alcohol. Tobacco smoking is an independent risk factor. Gene mutations can lead to hereditary chronic pancreatitis, (autoimmune pancreatitis type 1 is associated with increased levels of IgG4), and idiopathic disease, where no clear cause can be identified, accounts for 20-30% of cases.

Chronic pancreatitis can be difficult to recognise as its clinical features overlap with other gastrointestinal disorders. The typical presenting symptom is intermittent or continuous upper abdominal pain which may radiate to the back. The pain is commonly triggered or exacerbated by eating or alcohol consumption. Distal bile duct strictures may cause biliary obstruction and jaundice. Disruption of the pancreatic duct from previous episodes of pancreatitis can lead to pseudocyst formation. Pseudocysts may be asymptomatic but can result in pain, infection or gastric outlet obstruction. Pancreatic exocrine insufficiency (PEI) may cause weight loss and steatorrhoea, and endocrine insufficiency will lead to diabetes mellitus and its associated symptoms.

NICE recommends urgent referral to gastroenterology if the patient presents with a complication of chronic pancreatitis such as biliary obstruction. Otherwise, a routine referral is appropriate; while awaiting specialist input, GPs can conduct initial blood tests and request an abdominal ultrasound to rule out differential diagnoses. Pancreatic cancer is difficult to distinguish clinically from chronic pancreatitis, and an urgent suspected cancer referral may be indicated if the NICE criteria are met.

CT is the first-line imaging modality. MRCP has an advantage over CT in elucidating the pancreatic ductal anatomy in greater detail. PEI should be looked for with a stool sample for faecal elastase-1 and a nutritional assessment. Screening for diabetes mellitus should include both HbA_{1c} and fasting glucose as a normal HbA_{1c} does not exclude diabetes in this patient group. Serum amylase measurement is not useful in chronic pancreatitis.

Alcohol abstinence and smoking cessation are vital to reduce progression of the disease. Weight-bearing exercise reduces the risk of osteoporosis. Patients should have 6 monthly diabetes screening and yearly DEXA scans. NICE recommends initial pain management with paracetamol or ibuprofen, with progression to codeine if pain persists. Tricyclic antidepressants and neuropathic pain medication may be prescribed in secondary care.