# key points

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**Pancreatitis may be acute (AP) or chronic (CP). Although** both can be caused by similar aetiologies, they tend to follow distinct natural histories. Around 80% of AP diagnoses occur secondary to gallstone disease and alcohol misuse. The male: female ratio is 1.9:1. The incidence of AP in the UK has doubled since the 1960s, rising particularly in women under the age of 35, which may be associated with altered patterns of alcohol consumption. AP can lead to multi-organ failure and even death early in the course of the disease. If the disease is severe or prolonged, third space fluid losses and hypoperfusion can result in pancreatic necrosis and infection.

**CP follows continued, repetitive or sustained injury** to the pancreas and 70% of diagnoses occur secondary to alcohol abuse. It is characterised by gradual destruction of pancreatic parenchyma, which is replaced with fibrotic tissue, but is also associated with considerable catabolic stress and significant inflammatory responses. Pancreatic insufficiency, which develops as functioning cell mass is lost may result in decreased breakdown and absorption of nutrients, with steatorrhoea and weight loss, and eventually diabetes.

**AP is commonly associated with sudden onset of upper** abdominal pain radiating to the back that is usually severe enough to warrant the patient seeking urgent medical attention. Onset of pain may be related to a recent alcohol binge or rich, fatty meal. The patient may appear unwell, be tachycardic and have exquisite tenderness in the upper abdomen. Overall, 10-25% of AP episodes are classified as severe, leading to an associated mortality rate of 7.5%. Disease severity is best predicted from a number of clinical scoring systems which can be applied at diagnosis in association with repeated clinical assessment, measurement of acute inflammatory markers, and CT. All patients with suspected AP should be referred urgently.

**The characteristic presenting feature of CP is insidious** progression of chronic, severe, upper abdominal pain, radiating to the back, caused by a combination of progressive pancreatic destruction, inflammation and duct obstruction. Signs and symptoms include weight loss and steatorrhoea and later on diabetes. CP patients may also present with recurrent episodes mimicking AP, both symptomatically and metabolically. Diagnosis of CP should be based on symptom profile, imaging and assessment of exocrine and endocrine pancreatic function. CT should be the first-line imaging investigation.

**Elimination of the initiating factor is vital in the** management of AP as is effective supportive therapy. Nutrition is often a problem in both AP and CP as it can be limited by abdominal pain, nausea and vomiting and local complications. Alternative routes of feeding may become necessary. Abstinence from alcohol and stopping smoking should be encouraged. Pain can be initially managed with simple analgesics, but swiftly increasing doses are often required.