Acute Pancreatitis

Diagnosis, risk stratification, fluid resuscitation, ERCP timing, and nutrition in acute pancreatitis.

2024 ACG Clinical Guideline
Management of Acute Pancreatitis
Tenner et al. · Am J Gastroenterol 2024;119:419–437

GRADE — Strong Rec · Conditional Rec · Key Concept

1 Diagnosis & Etiology

STATEMENT	GRADE
Transabdominal ultrasound to evaluate for biliary pancreatitis; repeat if initial exam inconclusive	2 · Conditional
Idiopathic AP: further evaluation with repeat ultrasound, MRI, and/or EUS	2 · Conditional
Against routine early/admission CT for severity — reserve for unclear diagnosis or failure to improve by 48–72h	Key Concept
No gallstones/alcohol history: check **serum triglyceride** (etiology if >1,000 mg/dL)	Key Concept
Age >40 with no established etiology: consider pancreatic tumor	Key Concept
Second AP episode, no cause found, fit for surgery: cholecystectomy to reduce recurrence	Key Concept

2 Risk Stratification — SIRS & Severity Risk Factors

DOMAIN	CRITERIA
SIRS (≥2 of 4)	Pulse >90 · Respirations >20 or $PaCO_2$ <32 · Temp >38°C or <36°C · WBC >12,000 or <4,000 or >10% bands
Patient risk factors	Age >55 · Obesity (BMI >30) · Altered mental status · Comorbid disease
Labs at admission	BUN ≥20 mg/dL · HCT ≥44 · CRP ≥150 mg/dL · Creatinine ≥2 mg/dL

KEY — Stratify all patients by hemodynamic status and risk; those with **organ failure and/or SIRS** should preferably go to a **monitored bed**. Scoring systems/imaging alone are not accurate for predicting severe disease — remain **vigilant during the first 48h** regardless of initial severity.

3 Initial Management — Fluid Resuscitation

STATEMENT	GRADE
Moderately aggressive fluid resuscitation; add boluses if hypovolemic	2 · Conditional
Lactated Ringer's over normal saline for IV resuscitation	2 · Conditional
Use **caution with cardiovascular/renal comorbidity**; monitor for volume overload	Key Concept
Fluid resuscitation matters most **in the first 24 hours**; reassess frequently within 6h and over the next 24–48h with a **goal to decrease BUN**	Key Concept

4 ERCP & Post-ERCP Pancreatitis Prevention

STATEMENT	GRADE
Medical therapy over early ERCP (within 72h) in biliary AP **without cholangitis**	2 · Conditional
Cholangitis complicating AP: early ERCP within 24h reduces morbidity/mortality	Key Concept
Rectal indomethacin to prevent post-ERCP pancreatitis (PEP) in high-risk patients	1 · Strong
Pancreatic duct stent in high-PEP-risk patients also receiving rectal indomethacin	2 · Conditional

5 Antibiotics & Nutrition

STATEMENT	GRADE
Against prophylactic antibiotics in severe AP	2 · Conditional
Against FNA in suspected infected pancreatic necrosis	2 · Conditional
Mild AP: early oral feeding (within 24–48h) as tolerated, vs traditional NPO	2 · Conditional
Mild AP: initial **low-fat solid diet** rather than stepwise liquid-to-solid approach	2 · Conditional

Tenner S, Vege SS, Sheth SG, et al. American College of Gastroenterology Guidelines: Management of Acute Pancreatitis. *Am J Gastroenterol.* 2024;119(3):419–437.