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COURSE OF RECURRENT ACUTE PANCREATITIS AND CHRONIC PANCREATITIS; FOLLOW UP STUDY IN EASTERN INDIA

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ABSTRACT No data is available on the course of Recurrent acute pancreatitis(RAP) and Chronic Pancreatitis (CP) from the regions of eastern India. We carried out this study in J. L.N.Medical college & Hospital, Bhagalpur during a period of 30 months. One hundred and fifty patients were followed up over a median 15 months. Admitted patients with RAP and CP were followed up with a background of alcoholics and idiopathic and functional and structural changes observed.

KEYWORDS : Chronic Pancreatitis, Longitudinal studies, Recurrent acute pancreatitis , Steatorrhea

INTRODUCTION :

Acute pancreatitis can lead to RAP or CP, but repeated attack on RAP can lead to CP. In CP, morphological changes occurs as well pancreatic calculi, ductal dilation and exocrine and endocrine deficiency can take place. Alcohol and tobacco smoking are the contributory factors. We can predict the long term outcome and also develop treatment strategies by understanding the progression of pancreatitis. The aim of our study is to follow up patients with RAP and CP in our hospital for the progression of disease over time.

METHODS:

Patients with RAP and CP admitted in medicine and surgery department, J. L. N. Medical college &Hospital, Bhagalpur between June 2017 to December 2019 were taken for the study. Detailed evaluation for etiology and presence of diabetes mellitus and steatorrhea, intensity of pain, number of episodes and duration of each episodes were noted. Alcohol consumption more than 50g , per day was considered as a cause. Patients presenting with more than one episode of AP with complete resolution of symptoms in between and no evidence of CP on imaging was considered to have RAP. Patients were subject to abdominal USG, CT scan, MRCP and ERCP as per the presence of signs and symptoms. Patients with normal or indeterminate findings were classified as having RAP. CP was diagnosed over the presence of pancreatic calculi/ ductal changes on CT, MRCP or ERCP findings. Patients with RAP who had treatable cause ,such as biliary calculi and micro-calculi, hyper-calcemia and hyper-triglyceridemia were included. Malignancy causing obstructive pancreatitis were not included in this study.

Treatment:

Patients having moderate to severe pain were treated with NPO ,antibiotics and if needed analgesics and IV fluids .In few cases ,octreotide were given in acute cases. Once the pain subsided, they were given oral pancreatic enzymes supplements, PPI and antioxidants. Alcoholics were de-addicted and abstinence from smokings were advised. In 10 patients sphincterotomy done and stent placed in pancreatic duct.

Follow Up :

Patients were called for follow up every three months or whenever had pain in between . Plasma glucose and glycoselated hemoglobin (HbA1c) were measured every 6 months .On every 6 months, stool fat excretion was estimated. Steatorrhea was defined as excretion of > 7 gm/ day. If required, USG,CT ,MRCP or ERCP were done to see the pancreas in every 6 months. If new calcification, ductal dilation, steatorrhea or DM were seen, case was diagnosed as CP. Both idiopathic and alcoholic groups of patients were examined for 15 months, 15 patients lost during the period of follow up. 10 out of 50 RAP patients progressed to CP, evidenced by USG and CT. In idiopathic and alcohol subgroups of RAP, the disease progressed to CP is 10 out of 50.

The median time of progression was 15 months. Progression of CP seen in 15 patients by new onset of steatorrhea in 7 patients, DM in 2 patients , pancreatic calcification in 1 patient and ductal dilation in 10 patients. Few patients had more than one changes

DISCUSSION:

During follow up in our hospital, it has been seen that RAP patients progressed to CP and CP patients also progressed as evidenced by new onset diarrhea, development of diabetes ,calcification and ductal dilation during a median follow up period of 15 months. The time interval for the development of DM and pancreatic exocrine insufficiency ,may vary with the type of pancreatitis, study design, duration of follow up and the tests used. Exocrine insufficiency and diabetes mellitus occurred earlier in those with alcoholic pancreatitis and late onset of ICP as compared with early onset of ICP .Therapeutic interventions in patients with severe pain in RAP and stool fat excretion in CP lead to significant reduction. patients with RAP progressed to CP over a median time of 15 months .Progression of CP occurred similarly in idiopathic (20 %) and alcoholics (15%) subgroups.

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