PERT In Management Of Chronic Pancreatitis: Right and Optimal Therapy Choice

Mortality in CP

- 82 patients with chronic pancreatitis were followed-up for an average period of 25 months and none of them had an endoscopic treatment before inclusion in this study.
- Patients included were alcoholic in 84.2 % cases, pancreas divisum in 8.5% cases and idiopathic in 7.3% of cases.
- **Results**:

  Mortality Rate and Timing:

  - During the follow-up period, the overall mortality rate was 17% with average death time around 59 months.

  Causes of Death:

  - Pancreatic cancer, complications after surgery, and upper digestive hemorrhage were the most frequent causes of death, accounting for 3.6%, 3.6%, and 2.4% respectively.

  Mortality Risk Factors:

  - Presence of diabetes, lack of pain alleviation under treatment, and continuous smoking were identified as mortality risk factors.

•Individuals with chronic pancreatitis have a 3-4.5 times higher mortality rate than the general population.
•The 10-year survival rate after diagnosis ranges from 69% to 80%.

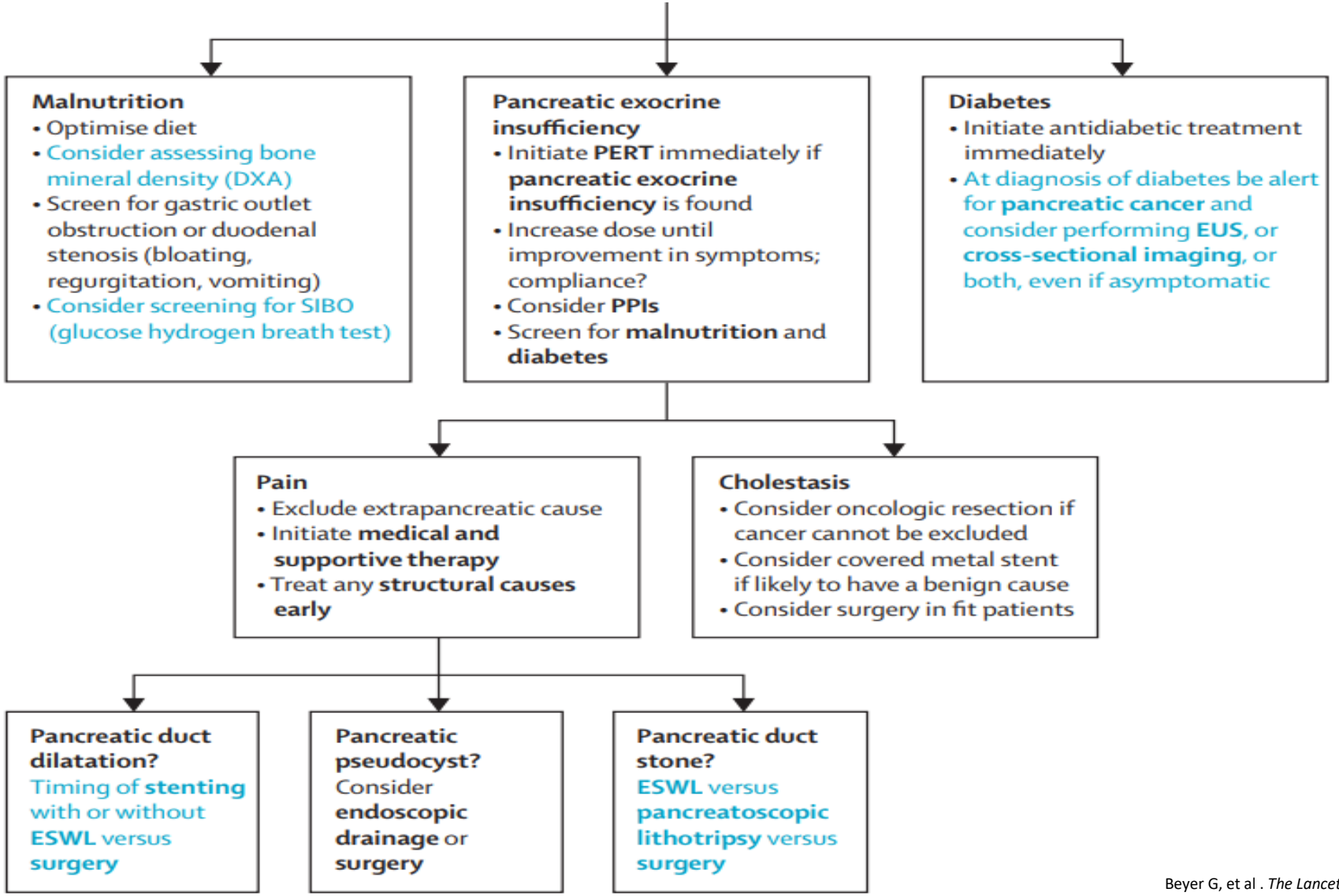
Seicean A, et al. *J Gastrointestin Liver Dis*. Mar 2006;15(1):21-6.

Gold Standard for PEI Management

FE1 should be repeated in cases of diagnostic doubt.	FE1 has a false positive rate of approximately 10%.[4] A low FE1 should be repeated in patients with a low pre-test probability of PEI, such as those lacking established risk factors.
Patients with PEI should undergo pancreatic imaging at diagnosis.	This provides structural information about the pancreas and excludes pancreatic cancer as a potential etiology.
Patients with PEI should undergo biochemical screening for malnutrition.	Malnutrition is common in patients with PEI, and responsible for significant morbidity if left untreated e.g. osteoporosis.
Patients with PEI should be prescribed PERT, at an initial dose of ≥40,000 IU/meal.	PERT is the cornerstone of PEI treatment. There is evidence that previous recommendations to start PERT at a dose of 20,000 IU/meal undertreats two-thirds of patients, therefore 40,000–50,000 IU/meal is now preferred.
Alcohol and smoking cessation should be advised.	Both alcohol and smoking are considered risk factors for the progression of PEI, particularly in patients with chronic pancreatitis.
Patients with PEI should be referred to a dietitian.	Dietary management is an important aspect of treatment. Dietitians are expert in assessing malnutrition, obtaining diet histories, and tailoring meal content and PERT regimens to individual circumstances.
Response to PERT should be monitored at follow-up.	Clinical response is a satisfactory outcome in most settings. Where available, the CFA or 13C-mixed triglyceride breath test can be used to identify patients with symptomatic improvement who remain at risk of malnutrition

Shandro BM, et al *Clin Med (Lond)*. Nov 2020;20(6):535-540. doi:10.7861/clinmed.2020-0506

Pain/Symptom management guidelines by International consensus (Cont.)



COPPS=Chronic Pancreatitis Prognosis Score. DXA= dual-energy x-ray absorptiometry. ESWL=extracorporal shock wave lithotripsy. EUS=endoscopic ultrasound. HbA1c=glycated haemoglobin A1c. M-ANNHEIM=Mannheim classification and prognosis score. PERT=pancreatic enzyme replacement therapy. PPIs=proton pump inhibitors. SIBO=small bowel intestinal overgrowth.

Beyer G, et al . *The Lancet*. 2020;396(10249):499-512.