Acute Pancreatitis in Children – A Disorder against whose Incessant Attacks Even Hercules could not have Stood

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Introduction

Acute pancreatitis is a reversible inflammatory process which results from auto-digestion of the pancreas from premature activation of pancreatic proenzymes [1]. Though reversible, this condition can lead to significant morbidity and mortality with up to a quarter of pediatric cases developing severe complications and mortality rates reaching up to 10% [2,3]. One of the proposed theories behind the death of Alexander the Great in 323 BC implicates acute pancreatitis [4]. The incidence of acute pancreatitis in children, like in adults, has been on the rise but acute pancreatitis has been clinically described since 1652. Dutch anatomist Tulp first described a young man with a suppurated pancreas on autopsy who presented with “continuous fever”, severe abdominal pain that “he had no possibility of lying down” and “was tortured to death by this agony in such a miserable way”, “against whose incessant attacks even Hercules could not have stood” [4-6]. This clinical scenario summarizes very well the presentation of acute pancreatitis. Clinical symptoms of acute pancreatitis include fever, nausea, vomiting, abdominal distension and constant epigastric abdominal pain aggravated by eating. In children, abdominal pain may be diffuse, back pain is less frequently involved and non-verbal children may present with irritability [7].

According to the 2012 consensus definition by the INSPPIRE consortium, the diagnosis of acute pancreatitis in children ≤ 18 years of age requires meeting two of three criteria (Table 1). Imaging features may include edema, necrosis, hemorrhage or abscess of the pancreas, peri-pancreatic inflammation or ascites. A pancreatic pseudocyst may also indicate a recent acute pancreatitis episode [7].

Table 1: Diagnostic criteria for the diagnosis of pancreatitis in paediatrics (from the INSPPIRE group recommendations).

<table>
<thead>
<tr>
<th>Common etiologies</th>
<th>Less common etiologies</th>
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<tbody>
<tr>
<td>Biliary disease</td>
<td>Metabolic disorders</td>
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<tr>
<td>Medication induced</td>
<td>Familial</td>
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<tr>
<td>Infectious</td>
<td>Hereditary</td>
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<tr>
<td>Trauma</td>
<td>Autoimmune</td>
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Table 2: Etiologies for acute pancreatitis in paediatrics.

Various imaging modalities are available but the most commonly used is transabdominal ultrasonography as it is non-invasive, does not involve radiation exposure or sedation. It is not necessary for the diagnosis of pancreatitis, if the other two criteria are met, as ultrasonography of the pancreas will often be normal especially early in the disease process and in mild disease. The pancreas may also be difficult to examine on ultrasonography in acute pancreatitis because of overlapping bowel gas from a localized ileus or pain-induced aerophagia where patients swallow large quantities of air [3]. Ultrasonography is useful, however, to identify obstructive biliary disease such as gallstones and choledochal cysts. Other imaging modalities that may be utilized include CT with IV contrast, endoscopic retrograde cholangiopancreatography (ERCP), endoscopic ultrasonography (EUS), or magnetic resonance cholangiopancreatography (MRCP) with/without secretin stimulation.

Management of acute pancreatitis is predominantly derived from adult data and there are no established pediatric guidelines. Fluid resuscitation is the cornerstone to managing acute pancreatitis and is typically done with isotonic fluids. There is new adult data to suggest that Lactated ringers may potentially be better than normal saline [10]. Patients will generally require more than maintenance IV fluids but there are no recommendations on volume or rate in pediatric patients. Very young children may have difficulties maintaining their glucose levels with fasting and dextrose containing solutions (typically 5-10%) should be considered in their hydration management as well as glucose and electrolytes monitoring.
No preferred analgesic has been identified in clinical trials but opioids, including morphine, are considered appropriate options. Historically there is a concern that morphine may cause spasm of the sphincter of Oddi but there is limited data to support this [8,11,12]. With mild pancreatitis, oral low fat diet can be initiated quickly after improvement of pain regardless of pancreatic enzyme levels. Enteral nutrition is reserved for cases unable to tolerate enteral nutrition. Studies have shown no difference between nasogastric and nasojejunal feeding [13,14]. Nasojejunal feeds require specialty placement under radiological or endoscopic guidance and can be considered if nasogastric feeds are not tolerated. Polymeric or elemental formulas may be used. Antibiotic prophylaxis is not recommended and its use is reserved for treatment in necrotizing pancreatitis [15].

Acute pancreatitis can be a devastating disorder and more data is needed to establish appropriate guidelines and improve care in pediatric patients with acute pancreatitis. There is a lot of ongoing research and the INSPPiRE consortium was partly formed to tackle these gaps. Certainly, standardization of systems and the development and dissemination of scoring tools and management guidelines are very valuable in the process of improving patient's care and outcomes [16]. This research is promising and will be able to help us better care for our young patients who have to battle a disorder whose "incessant attacks even Hercules could not have stood".

References