STANDARD OPERATING PROCEDURE

Acute Pancreatitis

Department of Health, Special Region (1)

Version: 1.0

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Review Date: Every 2 Years

Approved by: Emergency Medicine Unit

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1. Purpose

To provide a standardized protocol for the assessment, diagnosis, and management of patients presenting with acute pancreatitis, to ensure timely treatment and reduce morbidity and mortality.

2. Scope

Applicable to all healthcare providers (ER specialists, surgeons, anesthetists, medical officers, and nursing staff) managing patients with suspected or confirmed acute pancreatitis.

3. Responsibilities

Role	Responsibilities
Emergency Physician / Medical Officer	Initial assessment, stabilization, and referral.
Surgeon	Confirm diagnosis, initiate treatment, decide on interventions.
Anesthetist / ICU Team	Manage severe cases with multi-organ involvement.
MO / Nursing Staff	Monitoring, medication administration, fluid balance, patient support.

4. Procedure

A. Initial Assessment

Symptoms

- Severe epigastric pain radiating to back
- Nausea and vomiting
- History of gallstones or alcohol intake

Signs

- Abdominal tenderness and guarding

- Fever, tachycardia
- Hypotension (shock in severe cases)

B. Diagnosis & Investigations

Category	Details
Laboratory	Serum amylase/lipase (>3x normal is diagnostic), CBC, electrolytes, renal function, LFTs, serum calcium, triglycerides, CRP
Imaging	Ultrasound abdomen; CT abdomen with contrast (after 48 to 72 hours if severe or uncertain)
Severity Scoring	Ranson's criteria, BISAP score, APACHE II

C. Initial / Supportive Management

- Admit to hospital (ICU if severe)
- Nil by mouth depending on patient condition
- IV fluid resuscitation
- Oxygen supplementation to maintain SpO_2 > 95%
- Pain control
- NG tube if persistent vomiting or ileus
- Urinary catheter for fluid monitoring in severe cases

D. Specific Management

Gallstone Pancreatitis

- ERCP within 24 to 72 hours if cholangitis or obstructive jaundice present
- Cholecystectomy after recovery

Infective Complications

- IV antibiotics (carbapenems, quinolones, or metronidazole regimens)
- Drainage if abscess or necrosis present

Nutritional Support

- Early enteral feeding
- Parenteral nutrition if enteral not tolerated

E. Monitoring

- Hourly vital signs (severe cases)
- Daily laboratory tests: electrolytes, renal function, hematocrit
- Monitor for complications:
  - Shock
  - ARDS (Acute Respiratory Distress Syndrome)
  - Renal failure
  - DIC (Disseminated Intravascular Coagulation)
  - Sepsis

F. Discharge & Follow-up

- Gradual diet resumption
- Lifestyle modification: avoid alcohol, smoking, and high-fat meals
- Treat underlying cause
- Outpatient follow-up arranged

5. Documentation

The following documentation must be completed for all patients:

- Admission notes (history, examination findings)
- Resuscitation record
- Laboratory and imaging reports
- Progress notes (daily)
- Discharge summary with risk factor modification and follow-up instructions