Acute pancreatitis: When to reserve an ITU bed?

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Colorectal | Hepatobiliary | Pancreas

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The speaker outlined a risk-stratification approach for acute pancreatitis using SIRS criteria combined with IL-6 or CRP to identify patients requiring ICU admission, emphasizing early identification of the 15–20% who develop severe disease with mortality up to 50%.

KEY POINTS

- The speaker stated that persistent SIRS over the first 48 hours has 75–100% accuracy for severe course, and adding IL-6 above 160 pg/mL improves positive predictive value from 56% to 85%.
- Two mortality peaks occur: early (first 7 days) from sterile systemic inflammation and organ failure, and delayed (week 3–4) from infected pancreatic necrosis and septic complications.
- The speaker reported that about one-third of patients with infected necrosis do not need interventions when a step-up approach is used correctly.
- Specialized centres are defined as admitting at least 100 acute pancreatitis patients per year with 24/7 access to ICU, interventional endoscopy, radiology, and pancreatic surgery, and higher hospital volume correlates with lower mortality.
- CT severity indices are not better than clinical scores, and early CT underestimates necrosis extent, so the speaker does not recommend routine early imaging for severity prediction.
- In the Q&A, the speaker recommended transfer to an expert centre when SIRS plus elevated inflammatory markers are present, stating better safe than sorry despite imperfect positive predictive value.

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