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Summary

Panel discussion: Acute severe pancreatitis

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Endoscopy | Pancreas

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This panel discussion addressed management controversies in acute necrotizing pancreatitis, emphasizing individualized timing of drainage, antibiotic stewardship guided by procalcitonin and clinical parameters, and the need for better patient stratification to guide intervention decisions.

KEY POINTS

- The speakers stated that for infected pancreatic necrosis with organ failure, percutaneous drainage is recommended early when encapsulation is poor, with transition to endoscopic drainage after 3-4 weeks when the collection is walled off.
- Procalcitonin cut-offs of 0.5 for systemic infections and 0.2-0.5 for localized infections are used to guide antibiotic therapy, though PCT should be interpreted alongside clinical parameters including fever, leukocytes, and CRP rather than in isolation.
- The Waterland trial with 800 patients reportedly showed that lactated Ringer solution has anti-inflammatory effects with reduced SIRS incidence and lower CRP, though no impact on efficacy outcomes was observed.
- Preventive antibiotic treatment has shown no benefit in necrotizing pancreatitis across more than ten randomized trials, supporting a wait-and-see approach until infection is clinically evident.
- The speakers emphasized that decisions to drain collections are based primarily on clinical deterioration and multidisciplinary consensus rather than specific laboratory values or imaging features, with rapidly deteriorating patients having a stated 60-70% mortality risk within 72 hours.
- Acute necrotizing pancreatitis should not be treated as a single disease; the speakers advocated for better phenotypic stratification to identify subgroups who may benefit from earlier intervention versus conservative management.

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