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Summary

Pancreatic exocrine insufficiency

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Pancreas | Hepatobiliary | Endoscopy

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The speaker reviewed three major mistakes in managing pancreatic exocrine insufficiency based on new European guidelines that reframe PEI as a digestive problem requiring clinical context rather than isolated test results.

KEY POINTS

- The first mistake is assuming PEI occurs only in primary pancreatic diseases; the speaker reported that secondary causes include post-gastric surgery (a pilot study at Karolinska found 25% of gastrectomy patients had PEI) and coeliac disease (systematic review showed approximately 13% prevalence at diagnosis).
- The second mistake is relying solely on faecal elastase for diagnosis; the speaker cited a systematic review showing that using the 200 microgram per gram cutoff alone results in one-third of patients receiving wrong diagnosis and treatment, with sensitivity 94% and specificity 69%.
- The third mistake is prescribing insufficient PERT doses or failing to titrate; the speaker described starting with 40,000 to 50,000 units with main meals and half with snacks, then increasing to 75,000 if needed, with three treatment aims assessed at 4 to 6 weeks: weight normalisation, stool normalisation to Bristol type 3 or 4, and normalisation of fat-soluble vitamins and trace elements.
- Low faecal elastase and PEI are not synonymous; results must be interpreted in clinical context including stool consistency, imaging findings, and surgical history, and a therapeutic trial of PERT can confirm diagnosis if uncertainty remains.
- In the discussion, the speaker stated that patients can eat whatever they want and adjust PERT dose accordingly, abandoning the old paradigm of recommending a low-fat diet.

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