Panel discussion: Acute pancreatitis: Are we still innocent bystanders?

Postgraduate Teaching Programme Barcelona 2026 | Presentation

Surgery | Pancreas | Endoscopy

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This Q&A session addressed management controversies in acute pancreatitis including cholecystectomy timing, splenic vein thrombosis with varices, screening for exocrine insufficiency, and post-pancreatitis cancer surveillance.

KEY POINTS

- The speaker stated there is no indication for prophylactic cholecystectomy in asymptomatic gallstones, but in recurrent pancreatitis without microlithiasis on EUS, cholecystectomy reduces further episodes by at least 10% according to evidence presented.
- For splenic vein thrombosis with fundal varices in pancreatitis, the speaker described their practice as using beta blockers if no bleeding, possibly anticoagulation to monitor resolution, or experimental interventions like TIPS if clinically relevant, but emphasized there is no randomised trial evidence for any approach.
- The speaker does not recommend systematic faecal elastase screening for pancreatic exocrine insufficiency after pancreatitis due to lack of a perfect test and risk of overdiagnosis, advising instead to test only when symptoms develop.
- For post-pancreatitis cancer surveillance, the speaker's institution performs CT in pancreas protocol after one to two months when inflammation subsides, with the speaker noting that idiopathic pancreatitis with cyst carries almost 10% cancer risk in the next two to three years.
- The speaker reported no fixed protocol currently exists for following post-pancreatitis collections, though guidelines are being developed with a Pan European Consortium, and their practice includes systematic outpatient follow-up only for severe pancreatitis cases.

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