



FIGURE 38-4 Management algorithm for acute pancreatitis. Some of the guidelines, such as the diagnostic utility of the C-reactive protein (CRP) level, require further validation. Antibiotic use, including the type and duration of treatment, continues to be examined, and these suggested approaches will likely be modified by the findings of future studies. APACHE II, Acute Physiologic and Chronic Health Evaluation II; BISAP, Bedside Index for Severity of Acute Pancreatitis; CT, computed tomography; ERCP, endoscopic retrograde cholangiopancreatography; FH, family history; GPA, CT-guided percutaneous aspiration; GSP, gallstone pancreatitis; ICU, intensive care unit; LFTs, liver function tests; MSOF, multiple system organ failure; R/O, rule out; SIRS, systemic inflammatory response syndrome; TGs, triglycerides; TPN, total parenteral nutrition; US, ultrasound.

Options include total parenteral nutrition through central venous access or preferably as enteral feeding through a nasoenteric feeding tube. Enteral feeding is safer and less expensive than total parenteral nutrition and is associated with a reduction in systemic infection, need for surgical intervention, organ

failure, and mortality. Enteral feeding is usually well tolerated, even by patients with ileus. Nasogastric feeding may offer a safe alternative to nasojejunal feeding because it appears to be equally safe and effective. Parenteral nutrition should be reserved for patients who cannot achieve sufficient caloric intake through