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Editorial

Delayed Onset Post-ERCP Pancreatitis (DOPE-P)

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Post Endoscopic retrograde cholangiopancreatography (ERCP) Pancreatitis (PEP) is defined as new onset or worsening of pain abdomen after ERCP with an elevation of pancreatic enzymes (amylase/lipase) more than 3 times upper limit of normal after 24 hours of procedure and prolongation of hospital stay/planned admission.[1,2,3] The overall incidence of PEP is estimated to be 3-10%.[1,2,3] Various risk factors found in multivariate trials are divided into patient-related risk factor (prior PEP, female sex, young patient, normal bilirubin, previous recurrent pancreatitis, suspected sphincter of Oddi dysfunction, absence of chronic pancreatitis) and procedure-related risk factors (difficult cannulation i.e. >10 minutes cannulation time, repetitive pancreatic duct guide wire cannulation, pancreatic duct contrast injection, pancreatic sphincterotomy, endoscopic papillary large-balloon dilatation of an intact sphincter). Placement of prophylactic pancreatic stents (PPSs) usually advocated in high-risk patients and reduced PEP rate by 60-80%.[4,5] 3 Fr stents have higher migration rate and hence 5 Fr stents are superior to 3 Fr. Studies have shown that if placement of pancreatic stent is attempted but fails risk of PEP increases.[6]

There is scarce data available on incidence and severity of delayed onset post ERCP pancreatitis (DOPE-P).[7,8] DOPE-P is defined as the development of features of pancreatitis after the first 24 hrs of ERCP. It can occur in two situations: either early migration of prophylactic pancreatic duct (PD) stent within first day of ERCP or after endoscopic removal of PD stent. A retrospective cohort study of 230 patient undergoing PPS removal has shown 3% incidence of pancreatitis after pancreatic stent removal. Statistical significant risk factors found in this study were use of 5 fr a stent, stent with internal flange and history of PEP after initial ERCP.[8] Probable etiology of DOPE-P is trauma to PD caused by stent removal. There is a need for a prospective trial for incidence, severity and prevention of DOPE-P. Judicious use of PPS in the only high-risk ERCP with slow removal of PPS within 5-10 days or pharmacoprophylaxis with rectal Nonsteroidal anti-inflammatory drug (NSAIDs), if stent removal done after 10 days, it may theoretically decrease the incidence of DOPE-P. Guidelines recommends evaluation of self-migration of PPS within 5-10 days of placement and endoscopic removal if stent do not migrate with 5-10 days.[1]

CONFLICTS OF INTEREST

None.

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