

correct clinical context. The sensitivity of EUS (81%; 95% CI, 70–89%) to diagnose chronic pancreatitis is comparable to that of MRI/MRCP (78%; 95% CI, 69–85%) and better than CT (75%; 95% CI, 66–83%); however, nonspecific changes are commonly seen in the pancreas that may be attributable to cigarette smoking, diabetes, or normal aging. EUS also facilitates the delivery of nerve-blocking agents via fine-needle injection in patients suffering from pancreatic pain from chronic pancreatitis (celiac plexus block) or cancer (celiac plexus neurolysis). When clinically suspected, EUS imaging is more sensitive than MDCT for the detection of pancreatic malignancy and permits fine-needle aspiration/biopsy (FNA/B). Currently, EUS-guided FNA/B is the diagnostic modality of choice for the acquisition of diagnostic tissue and cyst fluid in patients with pancreatic masses and cystic lesions, respectively.

TABLE 347-3 Endoscopic Ultrasonographic Criteria for Chronic Pancreatitis (Total Criteria = 9)

DUCTAL	PARENCHYMAL
Stones	Echogenic strands
Hyperechoic main duct margins	Echogenic foci
Main duct irregularity	Lobular contour
Main duct dilatation	Cysts
Visible side branches	

Although a pancreatogram during ERCP is the most specific and sensitive test for evaluating the ductal anatomy, EUS and MRI/MRCP have largely replaced ERCP in the diagnostic evaluation of pancreatic disease to avoid the risk of complications. Therefore, ERCP is primarily of therapeutic value after CT, EUS, or MRI and MRCP has detected abnormalities requiring endoscopic treatment. ERCP is the most sensitive modality for the detection of bile duct stones. In the management of acute biliary pancreatitis, ERCP should not be unduly delayed in patients with high clinical suspicion of biliary obstruction. In chronic pancreatitis, ERCP abnormalities in the main pancreatic duct and side branches have been outlined by the Cambridge classification ([Fig. 347-2](#)). The presence of ductal