FIGURE 348-2 Imaging features of a pancreaticopleural fistula secondary to acute pancreatitis. ***A.*** Pancreaticopleural fistula: pancreatic duct leak on endoscopic retrograde cholangiopancreatography. Pancreatic duct leak (*arrow*) demonstrated at the time of retrograde pancreatogram in a patient with exacerbation of alcohol-induced acute pancreatitis. ***B.*** Pancreaticopleural fistula: computed tomography (CT) scan. Contrast-enhanced CT scan (coronal view) with *arrows* showing fistula tract from pancreatic duct disruption in the pancreatic pleural fistula. ***C.*** Pancreaticopleural fistula: chest x-ray. Large pleural effusion in the left hemithorax from a disrupted pancreatic duct. Analysis of pleural fluid revealed elevated amylase concentration. *(Courtesy of Dr. K.J. Mortele, Brigham and Women's Hospital; with permission.)*

■ ACUTE PANCREATITIS MANAGEMENT

The management of patients with acute pancreatitis from the time of diagnosis in the emergency ward to hospital discharge is briefly reviewed, highlighting salient features based on severity and complications. It is important to recognize that 85–90% of cases of acute pancreatitis are self-limited and subside spontaneously, usually within 3–7 days after onset, and do not exhibit organ failure or local complications.

The management of acute pancreatitis begins in the emergency ward. After a diagnosis has been confirmed, early and aggressive fluid resuscitation is critical. Additionally, intravenous analgesics are administered, severity is assessed, and a search for etiologies that may impact acute care is begun. Patients who do not respond to aggressive fluid resuscitation in the emergency ward should be considered for admission to a step-down or intensive care unit for aggressive fluid resuscitation, hemodynamic monitoring, and management of any organ failure.