

# AMERICAN GASTROENTEROLOGICAL ASSOCIATION

## American Gastroenterological Association Medical Position Statement: Treatment of Pain in Chronic Pancreatitis

*This document presents the official recommendations of the American Gastroenterological Association (AGA) on the Treatment of Pain in Chronic Pancreatitis. It was approved by the Clinical Practice and Practice Economics Committee on March 8, 1998, and by the AGA Governing Board on April 9, 1998.*

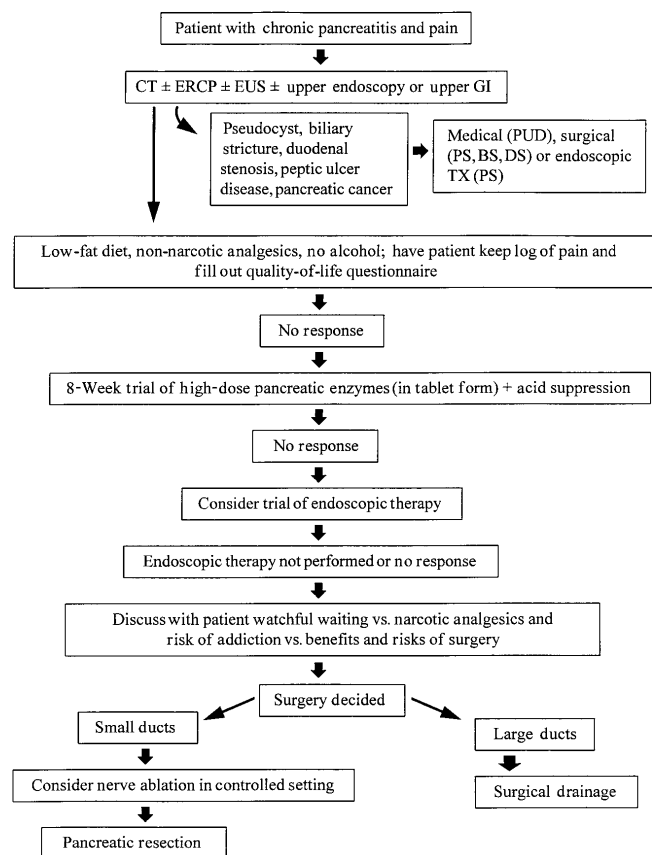
The management of abdominal pain in chronic pancreatitis can be a challenging problem. It is the symptom that most commonly brings the patient to medical attention and the one that is most difficult to control effectively. Its presentation varies through a wide spectrum, from mild and intermittent, to constant and disabling, leading to loss of work and frequent hospitalization. The potential for narcotic addiction is high and frequently compounded by a history of past or present alcohol abuse.

The heterogeneity of this patient population, the subjective nature of pain, and a poor understanding of its pathophysiology are all obstacles to studies directed at effectiveness of pain management. There are few controlled trials that meet high standards for clinical research and none that compare surgical and nonsurgical therapy.<sup>1</sup> Accordingly, there is no established standard of care. The following algorithm based on the data available may serve as a guideline (Algorithm 1). It begins by excluding other causes of pain, including both complications of chronic pancreatitis such as pseudocyst or biliary stricture and other conditions commonly found in this population such as peptic ulcer disease.

Assessment of the patient's pain and its nature, frequency, severity, and impact on other activities is key to objective decisions that may entail injurious interventions. A good way to begin is by having the patient keep a log of pain and by assessing quality of life with one of the available instruments.<sup>2</sup> After the initial assessment, a trial of high-dose pancreatic enzymes coupled with H<sub>2</sub>-blockers should precede the continuous use of narcotics or any invasive treatment.

At present, the evidence supporting the use of endoscopic therapy for pain in chronic pancreatitis is preliminary and largely confined to short-term focused observations. Although sphincterotomy, lithotripsy, and pancreatic duct stenting may hold promise, these procedures need further evaluation in clinical trials.

Although there have been no controlled trials comparing surgery with either medical treatment, endoscopic treatment, or no treatment, substantial experience indicates lasting benefit in at least some patients. However, the failure rate of 20%–40% in even the most enthusiastic reports, as well as the potential for surgical morbidity and mortality, warrant reserving surgical treatment for patients with severe pain not responsive to lesser tactics. The choice of operation, if elected, should be predicated on the morphology of the pancreatic ducts. Thoracoscopic nerve ablation is under investigation as an alternative to pancreatic resection in patients without dilated pancreatic ducts.



**Algorithm 1.** Guideline for treatment of pain in chronic pancreatitis.

## References

1. Warshaw AL, Banks PA, Fernández-del Castillo C. AGA Technical review on treatment of pain in chronic pancreatitis. *Gastroenterology* 1998;115:000-000.
2. Glasbrenner B, Adler G. Evaluating pain and the quality of life in chronic pancreatitis. *Int J Pancreatol* 1997;22:163-170.

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