NASPGHAN
NORTH AMERICAN SOCIETY FOR PEDIATRIC GASTROENTEROLOGY, HEPATOLOGY AND NUTRITION

Provider Creation Date: _____

PEDIATRIC PANCREATITIS PASSPORT AND ACTION PLAN

This patient has a known history of pancreatitis, and the current document is endorsed by the pancreas provider below. Please do not hesitate to contact them to discuss the pancreatitis action plan.

All information/suggestions contained in this form are not intended to replace the judgement of the treating physician

Patient Name:	**Diagnosis:** ☐ Acute Recurrent Pancreatitis ☐ Chronic Pancreatitis
Date of Birth:	**Parent/Guardian Contact:**
Pancreas Care Provider:	**Provider Contact:**

PANCREATITIS HISTORY

Brief History of Pancreatitis (1st episode, triggers, genetic/anatomic risk factors, surgeries/procedures, pancreatic insufficiency):
Patient Specific Acute Treatment/Medication Considerations:

Other Medical Problems/Allergies (◯ NKDA):	**Medications (Name/Dose/Frequency):**

PANCREATITIS ACTION PLAN AND RESOURCES

INFORMATION/SUGGESTIONS IN THIS FORM ARE BASED ON EVIDENCE AND EXPERT OPINION AT THE TIME OF CREATION AND NOT INTENDED TO REPLACE FUTURE MEDICAL ADVANCES OR THE JUDGEMENT OF THE TREATING PHYSICIAN

Workup	▪ **Labs to consider:** Complete blood count, liver function tests, electrolytes, lipase/amylase, triglycerides. Chronic pancreatitis patients may not have lipase/amylase that reach ≥3x upper limit of normal.
	▪ **Imaging:** Complete Abdominal Ultrasound. Consider MRCP or CT Abdomen w/contrast if concerned for pancreas complications. • Assess for fluid collection, biliary obstruction, and consider transfer to pancreas center if present.
	▪ **Assess for signs/symptoms of organ dysfunction:** Hypotension, capillary refill, oliguria, metabolic acidosis, elevated BUN/Cr, elevated liver function tests, thrombocytopenia, cyanosis, pulmonary edema.
Treatment	▪ **Fluid resuscitation:** 20 mL/kg (max 1L) IV fluid bolus and assess if additional fluid bolus is needed based on heart rate, capillary refill, estimated fluid deficit. After bolus: ≥1.5x maintenance IV fluids (LR or NS). • Follow markers of hemodilution (BUN, hematocrit, urinary output – Goal 0.5-1 mL/kg/hr). • Once intravascular fluid euvolemia → decrease to maintenance IV fluid rate. • Monitor for fluid overload (e.g., pulmonary edema, heart failure).
	▪ **Pain Control:** Pancreatitis can be incredibly painful. Analgesia management should be prompt and adjusted as needed to control pain, including the use of opioids when appropriate. Pain exacerbation episodes can occur without macroscopic pancreatic inflammation. • If mild pain and tolerating PO → avoid narcotic medications. • Opioid-sparing pain medications: Acetaminophen 15 mg/kg, ibuprofen 10 mg/kg, ketorolac 0.5 mg/kg. Avoid NSAIDs with elevated BUN/Cr. • Uncontrolled pain: Opiates are commonplace in chronic pancreatitis management and often used as adjuncts to opioid-sparing medications. Recommend judicious, but prompt, use of opiates for pain relief.
	▪ **Nutrition:** Regular diet is OK if patient has appetite, is not vomiting, and pancreatitis is not caused by hypertriglyceridemia. NPO in the short term if moderate/severe pancreatitis, if ileus, or other contraindications for enteral feeding.

Additional resources and treatment algorithms: https://naspghan.org/professional-resources/medical-professional-resources/pancreatic-disorders/

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In collaboration with the National Pancreas Foundation, Mission Cure, and Rebecca's Wish