**Title: The diagnostic value of the Rosemont ‘indeterminate’ and ‘suggestive’ criteria of chronic pancreatitis and the Japanese criteria of ‘possible’ and ‘early’ chronic pancreatitis**

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**ABSTRACT**

**Objective:** There is a lack of consensus on the criteria to diagnose ‘early’ chronic pancreatitis. The aim was to review the criteria on which a diagnosis of early chronic pancreatitis was based.

**Design:** Retrospective observational study in a single centre of the initial evidence for chronic pancreatitis, with reassessment after out-patient follow-up and review (from January 2003 to November 2016).

**Results:** Of 807 patients diagnosed with chronic pancreatitis 118 were reclassified, 52 with another diagnosis. In the remaining 66 patients there were 111 chronic pancreatitis associated risk factors: 38 were reclassified as chronic abdominal pain syndrome (CAPS) with ‘normal’ imaging and 28 had an initial finding of minimal change chronic pancreatitis (ifMCCP) at endoluminal ultrasound (EUS). Over a median (interquartile range) follow-up of 4.5 (2.2 – 6.7) years, there were 266 pancreas-imaging investigations with no progression to chronic pancreatitis in any patient. Using the Japanese diagnostic system, 11 of CAPS group would be classified as ‘possible chronic pancreatitis’ and the remaining 27 patients as ‘normal’. By the Rosemont classification eight patients with ifMCCP would be classed as ‘indeterminate chronic pancreatitis’ and 20 would have been classified as ‘normal’. The same eight patients would have classified as ‘early chronic pancreatitis’ by the Japanese system using EUS alone and xxx if the necessary clinical diagnostic criteria were also applied.

**Conclusion:** There needs to be a more stringent application (and consensus) of the systems used for diagnosing chronic pancreatitis with revision of the current terminology ‘indeterminate’, ‘suggestive’, ‘possible’, and ‘early’ chronic pancreatitis.

**Summary box:**

* **What is already known about this subject?**

There is no consensus as to the threshold number of diagnostic criteria needed to make a diagnosis of chronic pancreatitis in the absence of the classical features of calcification, dilated and structured main pancreatic duct, dilated side branches, pseudocyst, necrosis and structuring and other involvement of nearby organs.

There are nine features, four parenchymal and five ductal that can be identified using endoluminal ultrasound (EUS). There are two classification systems using only EUS (standard and Rosemont) and one that uses both EUS and clinical criteria (Japanese system) but they use overlapping and confusing classifications.

**Standard criteria** define three diagnostic classes: Normal or low probability, indeterminate, and high probability for chronic pancreatitis:

**Rosemont criteria** define four diagnostic classes: Normal, indeterminate, suggestive, and consistent with chronic pancreatitis

**Revised Japanese criteria** define three diagnostic classes: Possible, early chronic, and definite chronic pancreatitis.

* **What are the new findings?**

This study involved analysis of long term clinical follow-up data and found that over time 66 (8.2%) out of 807 patients initially diagnosed with chronic pancreatitis had insufficient criteria to sustain a diagnosis of chronic pancreatitis. There was no progression on imaging to sustain a diagnosis of chronic pancreatitis. Patients were variously diagnosed as having early, indeterminate and possible chronic pancreatitis using established criteria but also as having changes ‘consistent’ with chronic pancreatitis based on one or more standard EUS parenchymal or other imaging and clinical features but without reference to any of the actual classification systems.

* **How might this impact on clinical practice in the foreseeable future?**

The current terminology ‘indeterminate’, ‘suggestive’, ‘possible’, and ‘early’ chronic pancreatitis is very confusing and is not always understood and correctly applied.

There needs to be a more stringent application of existing systems used for diagnosing chronic pancreatitis. Ideally a new consensus is required to unify and simplify existing systems. There also needs to be a parallel process to agree a consensus on the pathological diagnosis of chronic pancreatitis, and ideally include early chronic pancreatitis, which is also lacking.

# **INTRODUCTION**

Chronic pancreatitis may be defined as a pathological fibro-inflammatory syndrome of the pancreas in individuals with genetic, environmental and/or other risk factors who develop persistent pathological responses to parenchymal injury or stress.[1] This will result in varying degrees of parenchymal fibrosis as well as, depending on the severity of the disease, ductal and parenchymal calcifications, inflammatory masses, biliary and duodenal stenosis, parenchymal necrosis and atrophy, islet cell loss, pancreatic fistulae, spleno-portal venous thrombosis and portal hypertension.[2, 3] Symptoms include those of diabetes mellitus malnourishment from pancreatic endocrine and exocrine failure and chronic abdominal pain.[2 3] The annual incidence rates range between 5 and 14.4 cases per 105 with a prevalence of around 50 per 105. [3-7] This prevalence is probably an underestimate for a variety of factors including disease definition, diagnostic challenges and patient compliance, and may as high as 120-143 per 105. [7] The median survival from diagnosis is around 15-20 years and the incidence appears to be rising for reasons that are not entirely clear. There is also an increased risk of developing pancreatic cancer with a standardized incidence of 14.4 to 19.0 in sporadic chronic pancreatitis,[8, 9] and up to 53 fold for hereditary pancreatitis. [10-12]

There have been major advances in our understanding of chronic pancreatitis most specifically genetic and environmental risk factors.[13-19] Whilst there have been considerable progress in imaging, the definition of and diagnosis of early chronic pancreatitis remains controversial and challenging.[20-21] Established chronic pancreatitis is relatively straightforward to diagnose when pancreatic duct calculi and/or parenchymal calcification are present and are readily identifiable with conventional imaging modalities such as computer tomography. [20-22] Computed tomography also provides information about glandular changes, main pancreatic duct dilatation and stricturing, atrophy, and pseudo-cyst formation as well as involvement of proximal vessels and organs. [20-23] Endoscopic ultrasonography (EUS) is a sensitive imaging modality for detecting subtle pancreatic ductal or parenchymal changes,[24] and superseded endoscopic retrograde cholangiopancreatography (ERCP). [25] The EUS Rosemont classification includes many features of the Cambridge classification, which was based on ERCP, but also provides information on the parenchyma. [24,25] The diagnosis of early minimal change chronic pancreatitis (MCCP) remains controversial because the threshold number of EUS criteria needed to establish the diagnosis unclear. [20] It is now apparent that many of the subtle parenchymal changes seen on EUS are variations of normal and may change with over time and with age. [26,27] Progression from MCCP based on EUS appearances to definite chronic pancreatitis is uncommon and EUS features of MCCP can revert to completely ‘normal’ appearances. [27] On the other hand studies from centres undertaking total pancreatectomy and islet auto-transplantation in adults with non-calcific chronic pancreatitis may indicate that EUS actually under diagnoses chronic pancreatitis. [28,29]

A diagnosis of chronic pancreatitis has life changing consequences and is compounded in individuals who suffer from chronic severe abdominal pain without any clear imaging to explain the symptoms. [30-32] As chronic pancreatitis is a progressive disease we hypothesized that patients with suspected or early chronic pancreatitis would develop clear evidence of the disease over time. [1,3,20,23,27] With evolving concepts of chronic pancreatitis against a background of evolving uncertainty surrounding the diagnosis of early disease, we reviewed a cohort of patients who had been under clinic follow up to determine whether an initial diagnosis remained consistent over time.

# **METHODS**

## **Study design and objectives**

The aim of the study was to review the clinical and imaging criteria on which a diagnosis of chronic pancreatitis was based, and with the benefit of clinical follow-up data, establish if the original diagnosis was correct. This was a single centre study based in the Regional Liverpool Pancreas Centre outpatient clinics at the Royal Liverpool University Hospital.

**Patients and patient selection**

All individuals with a potential diagnosis of chronic pancreatitis who were referred with a suspected diagnosis of chronic pancreatitis between January 2003 and November 2016 were included. All clinical records including demographic, clinical, genetic, radiological, endoscopic and histopathological details were re-reviewed by the senior clinician (J Neoptolemos) and the designated study investigator (A Sheel) between November 2015 and November 2016.

The database was enhanced to specify the presenting date and basis for the diagnosis of chronic pancreatitis, imaging results, and risk factors for chronic pancreatitis, including tobacco smoking, alcohol consumption. The results of genetic tests were checked including those of the serine protease inhibitor Kazal-type 1 (SPINK-1), the cystic fibrosis transmembrane conductance regulator (CFTR) and protease serine 1 (PRSS1). Radiological imaging modalities included CT, EUS, magnetic resonance imaging (MRI), magnetic resonance cholangiopancreatography (MRCP), and secretin stimulated MRCP. Excess alcohol intake was defined as consumption of ≥62 units (35 drinks) per week for ≥1 year. [33] Details were also recorded of clinical symptoms such as pain and severity, endocrine and exocrine insufficiency, documented hyperamylasaemia (upper limit of normal = 150 IU/L), attack(s) of acute pancreatitis, the type and amount of analgesia, length of follow-up, and the date and reasons for which the diagnosis of chronic pancreatitis was revised. Pancreatic exocrine insufficiency was based on clinical features from patient reported steatorrhoea and use of and response to pancreatic enzyme replacement therapy. Faecal elastase testing was abandoned as the accuracy for early chronic pancreatitis was found to be unreliable.[34, 35] Analgesics were classified into non-opioids (paracetamol and non-steroidal anti-inflammatory agents), adjuvants including neuropathic agents (anti-depressants, anti-epileptics, benzodiazepines, pregabalin and gabapentin), mild opioids (codeine, tramadol and hydrocodone) and strong opioids (morphine, oxycodone, hydromorphone, fentanyl, buprenorphine, and methadone). For simplicity only the use of strong opioids is reported.[36]

Based on all of the information from the initial to the last censored clinic visit, the diagnosis of chronic pancreatitis was either confirmed or rejected by at least two clinicians including the senior clinician and the designated study investigator. Patients who had their diagnosis of chronic pancreatitis revised were counselled by the senior team member and given further outpatient follow-up. Where appropriate further investigations or referral to other services (such as the chronic pain or gastroenterology team) was arranged.

## **Diagnostic criteria**

The Japanese system of diagnostic criteria for chronic pancreatitis was adopted for the purpose of this study. [21] There are six main diagnostic criteria: (1) characteristic imaging findings such as parenchymal calcification, ductal calculus, ductal morphological changes, and pseudocyst, (2) characteristic histological findings of loss of exocrine parenchyma with irregular predominantly interlobular fibrosis, (3) repeated upper abdominal pain, (4) elevated pancreatic enzyme levels in serum or urine, (5) reduced pancreatic exocrine function, and (6) continuous heavy drinking > 80g/day (10 units a day), using the Ammann criteria for a diagnosis of chronic pancreatitis secondary to alcohol.[37] A diagnosis of definite chronic pancreatitis requires criteria 1 and/or 2 to be met. Early chronic pancreatitis requires three of four ‘abnormal’ parenchymal findings (i-iv, see Table 1) plus at least three out of criteria 3-6. Possible chronic pancreatitis is diagnosed when patients have at least three of criteria 3-6, in the absence of either criterion 1 or 2, following the exclusion of other pancreatic diseases. A diagnosis of chronic pancreatitis was accepted at any time point during the follow up. This included the development of diagnostic features of chronic pancreatitis from previously normal or equivocal investigations indicative of minimal change chronic pancreatitis (MCCP). For comparison the standard classification, [38] which uses nine equally weighted criteria based on four parenchymal and five ductal features and the Rosemont classification, [24] are shown in (Table 1).

**Table 1.** Comparison of diagnostic systems using criteria based EUS features that may be associated chronic pancreatitis.

|  |  |  |  |
| --- | --- | --- | --- |
| Features of Chronic Pancreatitis | StandardCriteria(reference 38) | Japanese Criteria(reference 21) | Rosemont criteria(reference 24) |
| Parenchymal  | Hyperechoic foci  | i. Hyper echoic foci without shadowing | **Major A:** Hyperechoic foci (>2 mm in length/width with shadowing)**Minor:** Hyperechoic foci (>2 mm in length/width, without shadowing) |
| Hyperechoic strands  | ii. Stranding | **Minor:** Hyperechoic strands (≥3 mm in at least 2 different directions with respect to the imaged plane) |
| Lobularity | iii. Lobularity without honey combingiv. Lobularity with honey combing | **Major B:** Lobularity (≥3 contiguous lobules = ‘honeycombing’)**Minor:** Lobularity (>5 mm, non-contiguous lobules) |
| (Pseudo) Cysts | (Pseudo) Cysts | **Minor:** (Pseudo) Cyst (anechoic, round/elliptical with or without septations) |
| Ductal  | Main duct dilatation |  | **Minor:** Dilated duct (≥3.5 mm in body or >1.5 mm in tail) |
| Duct irregularity |  | **Minor:** Irregular duct contour (uneven or irregular outline and ectatic course)  |
| Hyperechoic margins | Hyperechoic main pancreatic duct margin | **Minor:** Hyperechoic duct wall (echogenic, distinct structure >50% of entire main pancreatic duct in the body and tail) |
| Visible side branches | Dilated side branches | **Minor:** Dilated side branch (>3 tubular anechoic structures each measuring ≥1 mm in width, budding from the main pancreatic duct) |
| Intraductal stones |  | **Major A:** Duct calculi (echogenic structure[s] within the main pancreatic with acoustic shadowing) |
| Diagnosis  | **Standard Criteria [38]** | **Japanese Criteria [21]** | **Rosemont criteria [24]** |
|  | **High probability for chronic pancreatitis:**5 to 9 criteria | **Definite chronic pancreatitis:**criteria 1 and/or 2(1) characteristic imaging findings (calcifications, calculus, ductal morphological changes),(2) characteristic histological findings of loss of exocrine parenchyma with irregular predominantly interlobular fibrosis | **Consistent with chronic pancreatitis:** 1 Major A feature + ≥3 minor features 1 Major A feature + major B feature 2 Major A features |
|  |  | **Early chronic pancreatitis:**EUS image findings of early chronic pancreatitis (three of i-iv) plus >3 out of criteria 3-6 and (3) repeated upper abdominal pain(4) elevated pancreatic enzyme levels (serum or urine)(5) reduced pancreatic exocrine function(6) continuous heavy drinking > 80g/day (10 units a day, Ammann criteria (37) | **Suggestive of chronic pancreatitis:**Major A + <3 minorMajor B + ≥3 minor≥5 minor, no major |
|  | **Indeterminate for chronic pancreatitis:**3-4 criteria  | **Possible** **chronic pancreatitis:** >3 of criteria 3-6, in the absence of criteria 1 or 2, with exclusion of other pancreatic diseases | **Indeterminate for chronic pancreatitis:**Major B + < 3 minor |
|  | **Normal or low probability of chronic pancreatitis:** 0-2 criteria |  | **Normal:**<3 minor, no major |

### **Statistics analysis**

Descriptive data are presented as median with inter quartile range (IQR). Continuous variables were analysed by the two-tailed Mann Whitney U test and categorical variables were compared using the χ2 test and for small numbers a two-tailed Fisher’s exact probability test. Ordered categories (number of risk factors) were analysed with a proportional odds model of cumulative percentages of patients in each group. [39] Significance was set at the 5 per cent level (p<0.05). P values are shown without Bonferroni correction as comparisons were exploratory, except where stated. The statistical package SPSS v22 was used.

**RESULTS**

From approximately 1100 adult patients reviewed for a possible diagnosis of chronic pancreatitis sufficient clinical and radiological data were available in 807 patients (526 men and 278 women) to be included in this study. The median (IQR) age was 57 (48-66) years. All had definite features of chronic pancreatitis on imaging, including 412 who had histological confirmation. Following review of the data, the diagnosis of chronic pancreatitis was rejected in 118 (14.6%) patients (Figure 1). An alternative true diagnosis was made in 52 patients: twenty-three patients had post acute pancreatitis radiological appearances only, 12 had idiopathic recurrent acute pancreatitis, five had intraductal papillary mucinous neoplasm and 12 had miscellaneous other diagnoses.

There were sixty-six symptomatic patients (8.2%) who were reclassified as having no diagnosis of chronic pancreatitis or any other alternative physical diagnosis. The clinical details are shown in Table 2. The median (IQR) duration of symptoms was nine (4-14) years. There were 266 specific imaging investigations of the pancreas, a median (interquartile range, IQR) of 4 (3-5) per patient, over a median (IQR) follow-up of 4.5 (2.2 – 6.7) years.

**Table 2**. Clinical features of patients reclassified into the chronic abdominal pain syndrome group and the initial finding minimal change chronic pancreatitis group.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Clinical Variables | Chronic Abdominal Pain SyndromeN= 38 | Initial finding of Minimal Change Chronic PancreatitisN=28 | \*Pvalue | TotalN=66 |
| Gender (Male: Female) | 19:19 | 17:11 | 0.388 | 36:30 |
| Age at first symptoms Median (IQR) years | 43 (31-47.5) | 38 (24.25-44.25) | 0.143 | 40 (30-46) |
| Duration of pain Median (IQR) years | 10 (4.25-14.75) | 9 (4.0-12.75) | 0.460 | 9 (4-14) |
| Clinical exocrine insufficiency | 6(15.8%) | 5(17.9%) | 0.539 | 11(16.7%) |
| Pancreatic enzyme supplements | 25(65.8%) | 15(53.6%) | 0.315 | 40(60.6%) |
| Insulin dependent diabetes mellitus | 3(7.9%) | 2(7.1%) | 0.644 | 5(7.6%) |
| Oral hypoglycaemics for diabetes mellitus | 4(10.5%) | 0(0%) | 0.102 | 4(6.1%) |
| Consumed ≥62 units per week of alcohol for ≥1 year | 13 (34.2 %) | 7 (25.0%) | 0.421 | 20 (30%) |
| Alcohol units consumption per week in excess drinkersMedian (IQR) | 160 (82-315) | 112 (70-560) | 0.968 | 116 (85-297.5) |
| Ever smoker  | 25 (65.8%) | 18 (64.3%) | 0.899 | 43 (65%) |
| Current smoker (%) | 12(31.6%) | 6(21.4%) | 0.360 | 18(27.3%) |
| Number of pack years in ever smokers Median (IQR) | 20(11.25-30) | 10(6-18) | **0.021** | 15(10-25) |
| Gainful employment | 8(21.1%) | 14 (50%) | **0.014** | 22(33.3) |
| Regular morphine and/or other strong opiate(s) | 31 (86.1) | 14 (50%) | **0.006** | 40 (60.6%) |
| Daily morphine or strong opiate(s) | 21 (55.3%) | 8 (28.6%) | **0.031** | 29 (43.9%) |
| Cholecystectomy | 11 (28.9) | 8 (28.6%) | 0.839 | 19 (28.8%) |
| One attack of acute pancreatitis | 12(31.6%) | 21(75.0%) | **\*\*<0.001** | 33(50.0%) |
| Deaths during study period  | 2 (5.3%) | 0(0%) | 0.328 | 2 (3.0%) |

\*P values are shown without Bonferroni correction as exploratory, except where stated.

\*\*P value with Bonferroni correction is significant, p<0.0029.

Thirty eight (4.7%) patients were diagnosed with chronic abdominal pain syndrome (CAPS) without any abnormal pancreas findings. Patients who were reclassified as CAPS, did not demonstrate any features of chronic pancreatitis on any radiological investigation performed. There were 28 EUS examinations in twenty-five (65%) of these 38 patients all with normal EUS examinations. Patients in this group also had 120 CT examinations and 14 MRCPs and secretin stimulated MRCPs. Based on the Japanese diagnostic system, eleven patients would have been classified as ‘possible chronic pancreatitis’ based on three or more of the following four criteria: repeated upper abdominal pain, elevated pancreatic enzyme levels, clinical features of reduced pancreatic exocrine function and heavy alcohol consumption. The remaining 27 patients would be classified as normal by the Japanese system. [21]

There were 28 (3.5%) patients with initial findings of MCCP on EUS without any progression of radiological features. In order to differentiate this group of patients from those with true MCCP they are called ifMCCP. All patients with ifMCCP had at least one report stating there were EUS features consistent with a diagnosis of chronic pancreatitis. According to the Rosemont classification no patients had a major A criterion, three patients had one major B with one minor criterion, four had four minor features, and four had three minor features, five patients had two minor features and seven patients had one minor criterion. None of these findings would give a diagnosis of chronic pancreatitis if the Rosemont classification were strictly applied. Eight patients would be classed as ‘indeterminate chronic pancreatitis’ and 20 would have been classified as ‘normal’. One patient was told that they had a diagnosis of chronic pancreatitis immediately following an EUS examination including a targeted parenchymal biopsy which was then found be of normal histology when the biopsy was microscopically examined. According to the Japanese system, the same eight patients would have classified as ‘early chronic pancreatitis’ this is not strictly correct only if they also had 3 or more of criteria 3 to 6. How many of them fulfilled the clinical criteria as well – not just the EUS criteria, you need both.

There were 33 (50.0%) patients who had had one attack of acute pancreatitis 12 (31.6%) in the CAPS group and 21 (75.0%) in the ifMCCP group, which was significant with a Bonferroni correction (p<0.001). Clinical characteristics comparing those with and without a history of acute pancreatitis in either group or as a whole showed no major differences (Table 3).

**Table 3.** Clinical characteristics comparing those with and without a history of acute pancreatitis in the chronic abdominal pain syndrome group and the initial finding minimal change chronic pancreatitis group.

|  |  |  |  |
| --- | --- | --- | --- |
| Clinical Variables | Chronic Abdominal Pain SyndromeN= 38 | Initial finding of Minimal Change Chronic PancreatitisN=28 | All Combined |
| **No Pancreatitisn=26** | **Previous pancreatitisn=12** | **\*P Value** | **No Pancreatitisn=7** | **Previous pancreatitisn=21** | **\*P Value** | **No Pancreatitisn=33** | **Previous pancreatitisn=33** | **\*P Value** |
| Gender: Men | 11(42.3%) | 8(66.7%) | 0.163 | 4(57.1%) | 13(61.6%) | >0.999 | 15(45.5%) | 21(63.6%) | 0.138 |
| Age at first symptoms Median (IQR) years | 40.5(30.3-46) | 46(41-48.5) | 0.314 | 31(22.5-36) | 39(30.3-45) | 0.114 | 37(29-45) | 42(35.5-47) | 0.328 |
| Duration of pain Median (IQR) years | 9(4-14.75) | 10(6-15) | 0.671 | 13(9.5-15) | 6(3-9) | **0.026** | 10(4-15) | 7(4-12) | 0.267 |
| Clinical exocrine insufficiency | 3(11.5%) | 3(25%) | 0.357 | 0(0%) | 5(23.8%) | 0.290 | 3(9.1%) | 8(24.2%) | 0.099 |
| Pancreatic enzyme supplements | 19(73.1%) | 6(50%) | 0.270 | 6(85.7%) | 9(42.9%) | 0.084 | 25(75.8%) | 15(45.5%) | **0.012** |
| Insulin dependent diabetes mellitus | 0(0%) | 3(25%) | **0.026** | 0(0%) | 2(9.5%) | >0.999 | 0(0%) | 5(15.2%) | 0.053 |
| Oral hypoglycaemics for diabetes mellitus | 3(11.5%) | 1(8.3%) | >0.999 | 0(0%) | 0(0%) | N/A | 3(9.1%) | 1(3%) | 0.613 |
| Consumed ≥62 units per week of alcohol for ≥1 year | 11(42.3%) | 2 (16.7%) | 0.158 | 1(14.3%) | 6(28.6%) | 0.639 | 12(36.4%) | 8(24.2%) | 0.284 |
| Alcohol units consumption per week in excess drinkers Median (IQR) | 160(100-240) | 221(143.3-299.8) | >0.999 | 90(90-90) | 116(80.5-450) | 0.611 | 130(97.5-220) | 116(70-423.5) | 0.816 |
| Ever smoker  | 17(65.4%) | 8(66.7%) | >0.999 | 5(71.4%) | 13(61.9%) | >0.999 | 22(66.7%) | 21(63.6%) | 0.796 |
| Current smoker | 8(30.8%) | 4(33.3%) | >0.999 | 3(42.9%) | 3(14.3%) | 0.144 | 11(33.3%) | 7(21.2%) | 0.269 |
| Number of pack years in ever smokers Median (IQR) | 16(10-30) | 30(20-30) | 0.233 | 10(7.5-18) | 11(6.5-17) | 0.884 | 15.5(9.8-27) | 15(10-20) | 0.600 |
| Gainful employment | 7(26.9%) | 1(8.3%) | 0.393 | 2(28.6%) | 12(57.1%) | 0.385 | 9(27.3%) | 13(39.4%) | 0.296 |
| Regular strong opiates | 20(76.9%) | 11(91.7%) | 0.395 | 6(85.7%) | 8(38.1%) | 0.077 | 26(78.8%) | 19(57.6%) | 0.064 |
| Daily strong opiates | 14(53.8%) | 7(58.3%) | 0.796 | 3(42.9%) | 5(23.8%) | 0.371 | 17(51.5%) | 12(36.4%) | 0.215 |
| Cholecystectomy | 5(19.2%) | 5(41.7%) | 0.235 | 3(42.9%) | 5(23.8%) | 0.371 | 8(24.2%) | 10(30.3%) | 0.580 |
| Deaths during study period  | 1(3.8%) | 1(8.3%) | 0.538 | 0(0%) | 0(0%) | N/A | 1(3%) | 1(3%) | >0.999 |

\*P values are shown without a Bonferroni correction

The EUS appearances in these patients are shown in Table 4. The EUS for twelve patients was performed within 9 months of an acute episode of acute pancreatitis (XX in the CPAS group and XX in the ifMCCP group) with a total of xxx EUS features compared to those who had an EUS after a longer interval with a total of XXX features.

**Table 4.** EUS features in patients with a history of acute pancreatitis in the chronic abdominal pain syndrome group and the initial finding minimal change chronic pancreatitis group.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EUS StandardCriteria(reference 38) | Acute Pancreatitis in Chronic Abdominal Pain Syndrome | Acute Pancreatitis in Initial finding of Minimal Change Chronic Pancreatitis | \*Pvalue | Total |
| Patients with history of acute pancreatitis | 12 (31.6%) of 38 | 21 (75.0%) of 28 | **\*\*<0.001** | 33 (50.0%) of 66 |
| Patients with EUS features  | 12 | 21 |  | 33 |
| Patients with classified EUS features  | 12 | 14 |  | 26 |
| PARENCHYMAL FEATURES |  |  |  |
| Hyperechoic foci | 1 (8.3%) | 8 (57.1%) | **0.014** | 8 (30.8%) |
| Hyperechoic strands  | 1 (8.3%) | 5 (35.7%) | 0.170 | 6 (23.1%) |
| Lobularity 1. Without honey combing
2. With honey combing
 | 2 (16.7%)0 (0%) | 6 (42.9%)3 (21.4%) | 0.2160.225 | 8 (30.8%)3 (11.5%) |
| (Pseudo) Cysts | 2 (16.7%) | 3 (21.4%) | >0.999 | 4 (15.4%) |
| DUCTAL FEATURES |  |  |  |  |
| Main duct dilatation | 0 (0%) | 0 (0%) | - | 0 (0%) |
| Duct irregularity | 0 (0%) | 2 (14.3%) | 0.483 | 2 (7.7%) |
| Hyperechoic margins | 0 (0%) | 6 (42.9%) | **0.017** | 6 (23.1%) |
| Visible side branches | 0 (0%) | 0 (0%) | - | 0 (0%) |
| Intraductal stones | 0 (0%) | 0 (0%) | - | 0 (0%) |

\*P values are shown without Bonferroni correction as exploratory, except where stated.

\*\*P value with Bonferroni correction is significant, p<0.0029.

None of the patients with EUS appearances of ifMCCP demonstrated radiological progression in any imaging modality over a median (IQR) follow period of 4.9 (2.9-6.2) years. Five patients underwent repeat EUS at a median (IQR) of 3.0 (2.1-6.0) years between tests, with all five showing resolution of ifMCCP related changes. The remaining 23 patients were followed up using other imaging modalities and these were normal. Examples of radiological imaging in these patients, including regression of ifMCCP changes at EUS is given in Figures 2 and 3, and comparative example of radiological progression from MCCP at EUS is given in Figure 4.

Forty patients underwent genetic testing for alterations in SPINK-1, CFTR and, if a family history of pancreatitis present, PRSS1 genes. There were four positive results; three patients had heterozygous CFTR ΔF508 mutation (frequency = 7.5%) and one patient had a heterozygous SPINK-1 N34S variant (frequency = 2.5%). Three of these patients had previously had one episode of acute pancreatitis (two with a CFTR ΔF508 mutation and with SPINK-1 N34S).

**Table 5.** The number of recognised risk factors for chronic pancreatitis identified in the population, including significant alcohol consumption, tobacco smoking, previous episode of acute pancreatitis, and altered predisposing gene(s).

|  |  |
| --- | --- |
| Patient Group | Number of Risk Factors |
|  | **0**  | **1**  | **2**  | **3**  | **4**  |
| Chronic Abdominal Pain Syndrome |
| Number of patientsN=38 | 6(%) | 11(%) | 16(%) | 5(%) | 0 |
| Total number of risk factorsN=58 | 0(%) | 11(%) | 32(%) | 15(%) | 0 |
| Initial finding of Minimal Change Chronic Pancreatitis |
| Number of patientsN=28 | 2(%) | 10(%) | 6(%) | 9(%) | 1(%) |
| Total number of risk factorsN=53 | 0(%) | 10(%) | 12(%) | 27(%) | 4(%) |
| Total number of patientsN=66 | 8(%) | 21(%) | 22(%) | 14(%) | 1(%) |
| Total number of risk factorsN=111 | 0(%) | 21(%) | 44(%) | 42(%) | 4(%) |

All patients reported severe abdominal pain as their main symptom. The analgesic requirements were substantial. Forty patients (60.6%) required regular morphine and other strong opiates and 29 (43.3%) required this daily. More patients in the CAPS group had greater analgesic requirements than the ifMCCP group and many more were not in gainful employment. Five patients required repeated ketamine infusions for pain control, three of which had previous EUS diagnosing ifMCCP. Two of these underwent a further EUS demonstrating a ‘normal’ pancreas. Fifteen patients reported symptoms that could be attributed to pancreatic exocrine insufficiency, which was mostly occasional diarrhoea, although 40 of the patients had been prescribed pancreatic enzyme supplementation during their follow-up regardless of the presence or absence of diarrhoea/steatorrhoea in their history.

Fifty eight (87.9%) of the combined CAPS and ifMCCP individuals had at least one recognised risk factor for chronic pancreatitis and all reported symptoms of abdominal pain (Tables 2 and 3). There was no significant difference in the number of risk factor categories between the ifMCCP and the CAPS groups (Fishers exact probability test, p = 0.102), and nor in the differences in the overall number risk factors by ordered categories (odds ratio = 1.84, 95% confidence interval = 0.75, 4.53; p-value = 0.255).

There were 23 surgical or endoscopic interventions undertaken. Nineteen patients had a cholecystectomy of which two had no gallstones. Two had a limited pancreatic necrosectomy for necrotising acute pancreatitis, and one underwent an ERCP and sphincterotomy for sphincter of Oddi dysfunction. Only four 12 individuals were gainfully employed (18.8%), 44 (66.7%) were unemployed, six (9.1%) had a prolonged absence from work, and four (6.1 2 cases of all-cause mortality. There were two deaths one in a current smoker who died of metastatic lung cancer, the other had a history of significant alcohol excess and died of complications from portal hypertension.

**DISCUSSION**

This study found that 118 (14.6%) of 807 patients of had been previously misdiagnosed as having chronic pancreatitis, 52 with another diagnostic pathological processes and 66 without any alternative physical diagnosis. Thirty-eight patients had severe chronic abdominal pain with normal imaging of the pancreas, of whom 32 also had between one and three risk factors associated with chronic pancreatitis. These patients were therefore reclassified as having chronic abdominal pain syndrome. As well as having more strong opioid analgesic requirements than the ifMCCP group they also had a much higher rate of unemployment. Eleven of these patients would have been classified as ‘possible chronic pancreatitis’ according to the Japanese diagnostic criteria but did not evolve into chronic pancreatitis with follow-up.[21] The remaining 27 patients would have been classified as normal.

A further 28 patients were diagnosed with chronic pancreatitis based on EUS findings in the presence of abdominal pain. Strict adherence to the Rosemont classification resulted in eight patients classed as ‘indeterminate chronic pancreatitis’ and 20 would have been classified as ‘normal’. With further follow-up and a a median of four investigations per patient, no patient from either group displayed any imaging evidence of progression to chronic pancreatitis and in xxx cases reversion of EUS imaging to normal. Both groups of patients had a similar number and distribution of risk factors, so the presence or absence of one or more risk factors alone cannot be used to infer a definite diagnosis of chronic pancreatitis in the absence of characteristic imaging findings or histopathology. There were 33 patients with a documented attack of acute pancreatitis of whom three had a predisposing gene alteration (two with a CFTR ΔF508 mutation and with SPINK-1 N34S) but with subsequent resolution of imaging.

Features of post-acute pancreatitis seen on co-axial imaging and EUS can take 12 months or more to resolve (in the absence of necrotising pancreatitis at the initial attack), usually lagging behind the resolution of symptoms. In the present series 23 of the 118 patients with no clinical or radiological evidence of chronic pancreatitis had resolving post acute pancreatitis imaging findings and another 12 patients had recurrent acute pancreatitis with resolution of symptoms and imaging in between attacks.

A number of studies have taken patients with a single episode of non-gallstone acute pancreatitis, recurrent non-gallstone acute pancreatitis, acute pancreatitis with a background of acute pancreatitis, and chronic pancreatitis per se, [1-3, 20, 23] and grouped these together into a single study population causing difficulties in interpretation. [23,28,29] The problem is further compounded by the lack of consensus as to the pathological definition of early chronic pancreatitis. In 1996 Ammann, Heitz and Klöppel compared a fibrosis scoring system (range 0-12) with a pancreatic function index based on (1) the fecal chymotrypsin test and (2) diabetes mellitus (range 0–5) in patients with alcohol related chronic pancreatitis.[40] In this system a fibrosis score of 2 could derive from mild focal perilobular and mild focal interlobular fibrosis whilst a function index of 1 could derive simply from a marginal reduction in faecal chymotrypsin or a normal faecal chymotrypsin value but prescribed an oral hypoglycaemic. There were 10 (12.0%) out of 83 patients investigated with fibrosis scores of 0-3 and a mean function index of 1 and another 16 (19.3%) with a fibrosis score of 4-6 with a mean function index of just above 1.[40] A step change occurred at a fibrosis score of 7-9 when the mean function score jumped to 2.[40]

Despite the lack of validation and consensus as to the diagnostic threshold of the fibrosis score for chronic pancreatitis a number of studies have used a fibrosis score of >2 as being indicative of chronic pancreatitis.[28,29,41,42] In a series of 50 adults with non-calcific chronic pancreatitis that underwent total pancreatectomy and islet auto-transplantation 42 had a fibrosis score of >2, but in eight (16%) patients the score was only 0-1. [29] None of these patients had a diagnosis of chronic pancreatitis using the Rosemont classification. In the group with a fibrosis score of >2, the Rosemont criteria classified 5 as normal, 12 as indeterminate and 25 as suggestive of chronic pancreatitis and in the patients with a score of only 0-1, EUS classified 4 as normal, 3 as indeterminate and one as suggestive. [29] It was unexplained why 84% were women and nearly three-fourth of these patients had a history of acute pancreatitis needing hospitalization. In the patients with recurrent acute pancreatitis, EUS was performed 6-8 weeks after an episode of acute pancreatitis.[29] So it remains unclear whether the fibrosis (and pancreatic function) as well as the EUS features observed in this study reflect post acute pancreatitis sequelae rather than underlying chronic pancreatitis.

A study by LeBlanc et al of 100 surgical patients identified an increased odds ratio for severe pancreatic fibrosis (score 9-12) associated with hyperechoic foci with and without shadowing, lobularity with honeycombing, main pancreatic duct dilation or irregularity, and dilated side branches.[41] They also found a relatively poor accuracy of EUS for early chronic pancreatitis with a sensitivity and specificity of >3 EUS criteria for mild fibrosis (score 1-4) of 54% and 22% respectively in the head of the pancreas, and 63% and 15% respectively in the body and tail of the pancreas. [41] In another surgical series Chong et al also reported a poor correlation between EUS criteria and the fibrosis score. [42].

In the present study no patient demonstrated any progression on imaging to features of chronic pancreatitis and all five patients with ifMCCP who had a repeat EUS showed complete resolution to normal appearances within a median follow-up of 3 years, consistent with findings from Japan.[27]

This study has highlighted the challenges in diagnosing early chronic pancreatitis in patients that may have some features of chronic pancreatitis, including certain risk factors, abdominal pain in a proportion, and around half with one previous documented attack of acute pancreatitis. EUS criteria were often overcalled in making a presumptive diagnosis of chronic pancreatitis. With follow up none of the patients developed features of chronic pancreatitis. Using the Japanese diagnostic system, [21] eleven of 38 patients in the CAPS group would have been classified as ‘possible chronic pancreatitis’ and the remaining 27 patients would be classified as normal. In patients with ifMCCP, using the Rosemont classification,[24] eight patients would be classed as ‘indeterminate chronic pancreatitis’ and 20 would have been classified as ‘normal’. The Japanese system, would have classified the same eight patients as ‘early chronic pancreatitis’ using EUS alone and xxx if the necessary clinical diagnostic criteria were also applied.

Caution is needed in managing patients with the Rosemont diagnosis of ‘indeterminate chronic pancreatitis’ or ‘suggestive of chronic pancreatitis’, [24] and similarly the revised Japanese diagnosis of ‘possible chronic pancreatitis’ or ‘early chronic pancreatitis’. [21] In the present series the application of a time factor for follow up should be applied in patients with an uncertain diagnosis to determine complete resolution to normal or progression to chronic pancreatitis of say 24 months. Consensus is also required for the diagnosis early chronic pancreatitis by histopathological criteria as the use of a fibrosis score of >2 is not convincing from the published studies.

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**LEGENDS TO FIGURES**

**Figure 1.** CONSORT diagram of the study. CP = chronic pancreatitis, IPMN = intraductal papillary mucinous neoplasm, CAPS = chronic abdominal pain syndrome, MCCP = minimal change chronic pancreatitis, EtOH = alcohol.

**Figure 2.** Imaging from a patient previous diagnosed with chronic pancreatitis, now reclassified as chronic abdominal pain syndrome.

**Figure 3.** Representative images from two patients with initial finding of minimal change of chronic pancreatitis. 3(A) demonstrates no disease progression, and 3(B) demonstrating regression of initial finding of minimal change of chronic pancreatitis on EUS examination.

**Figure 4.** Example of a patient with disease progression to chronic pancreatitis.

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