Pancreatitis: scope workshop discussions – Group 1 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.1. Who is the focus: **Groups that will be covered: (Page 2 line 28)** **Children, young people and adults with acute or chronic pancreatitis** **Groups that will not be covered: (Page 2 line 30)** **Children, young people and adults with pancreatic cancer**	• The DH remit is for the diagnosis and management of pancreatitis. • Are there any specific subgroups that have not been mentioned (in either list)?	Paediatrics: Very rare instances of chronic pancreatitis as the child would not have lived long enough to develop this illness. Most cases, are therefore 'acute pancreatitis'.
1.2. Settings **Settings that will be covered (Page 2 line 34)** 1.2.1. All settings in which NHS commissioned care is provided.	• Are the listed settings appropriate?	No Comment.
1.3. Activities, services or aspects of care: **Key areas that will be covered (page 2 line 40)** 1.3.1. Fluid resuscitation for people with acute pancreatitis. 1.3.2. Use of antibiotics for people with acute pancreatitis (including both who should get them and the type of antibiotics). 1.3.3. Referral of people with acute pancreatitis. 1.3.4. Management of infected necrosis for people with acute pancreatitis. 1.3.5. Management of pancreatic ascites and pleural effusion for people with pancreatitis (acute and chronic). 1.3.6. Diagnosis of chronic pancreatitis. 1.3.7. Assessment of aetiology for people with chronic pancreatitis or idiopathic recurrent acute pancreatitis. 1.3.8. Management of chronic pancreatitis, including management of: 1.3.8.1. Pseudocysts 1.3.8.2. Fistulae 1.3.8.3. Haemorrhage 1.3.8.4. Pancreatic duct obstruction	• These are the key clinical areas that have been prioritised for inclusion in the guideline. • Do you think that these prioritised areas are appropriate for the topic? • Have any areas not been mentioned?	General: Pain should be covered for both acute and chronic pancreatitis. 1.3.1 Not consistently done across the service. Covered in existing industry guidance. Practice varies in both the speed of administration and the type of fluid used. IV Fluids guidance will not apply as enormous inflammation problem needs to be address in acute pancreatitis patients, and this needs to be managed with aggressive resuscitation. Low resuscitation would affect outlook for patient. More focused resuscitation ned to get the patient's Blood Pressure up and resuscitation needs to be continued until fluid levels have been achieved. Type of fluid used will be different from other populations. 1.3.2 Antibiotics are used in patients with acute pancreatitis as a strategy for treating infected necrosis and also as a prophylactic treatment, both are important. Current clinical practice sees a lot of inappropriately prescribed antibiotics. The type of antibiotics used across the service is also inconsistent. It is also challenging identifying infection in patients with acute pancreatitis. 1.3.3 Referral. All acute pancreatitis patients should have specialist input, either in a specialist centre, or through discussions with specialist physician. Key is to identify the group that will do the

Pancreatitis: scope workshop discussions – Group 1 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.3.8.5. Biliary obstruction. 1.3.9. Malabsorption or malnutrition in people with chronic pancreatitis. 1.3.10. Location, frequency and investigations of follow up for people with chronic pancreatitis. 1.3.11. Surveillance for pancreatic cancer in people with chronic pancreatitis. 1.3.12. Information and support needs for people with chronic pancreatitis.		worst. Earliest identification is best. No specialist knowledge is needed for identification. The current national practice is to use patient stats as input into a scoring system. This helps clinicians determine if the disease is not settling down. The group thought the best approach to the issue is to ask: 'What's the best indication of severity indicating the need for specialist care?' The services available in the specialist centre include: endoscopic and radiological expertise and surgery to remove build up or drain excess fluids. This was highlighted as an HE Issue. As referral would reduce hospital stay, identify the need for specialist centre support, and possibly move patient off of the ICU ward sooner. 1.3.4 and 1.3.5 The group thought these were very important for inclusion, but anticipated a paucity of evidence. The group clarified that pancreatic ascites were caused by the pancreatitis self-corroding due to a disruption in the organ. The fistulae was described as a fusion of the pancreas to part of another organ and a leak developing in the pancreas. It was thought that there would be similar treatment for both situations: fluid reduction. And efforts to resolve the duct disruption. 1.3.6 Diagnosis and 1.3.7 assessment of aetiology. Important to prioritise this as there is huge variance across the service. Looking for other metabolic causes is important. There are however limitations on the scans available. Ultrasound is good for gall stone detection, but not good for identifying bile duct problems. MRI good but not past 5 mm. Endoscopic ultrasounds have a limitation on the resolution of images. Radiological investigations are good – but may not always be available. The group suggested the following question would be useful for the guideline: 'What tests needed in specific circumstances and in what sequence'. In current practice the availability of the MRCP varies by region. If the patient has seen a surgeon there have generally had an MR. But there are instances where Auto immune pancreatitis is a possibility, for example, in patients who have had salivary glands removed. Regarding diagnosis. Some diagnosis is obvious and easy for non-specialists to spot. The issue arises with difficult cases, for example –

Pancreatitis: scope workshop discussions – Group 1 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
		recurrent, idiopathic acute pancreatitis of unknown cause. These patients need to be seen by specialists in the treating hospital and require a tailored approach to their care. The group was keen for clarification on the sequence of tests to be used during diagnosis. The group thought a pathway would emerge that indicates that non-invasive tests should be done first as invasive tests raises patient risk. Small duct disease and minimal change disease were mentioned by the group – this was an example of pancreatitis where there is no calcium build up but chronic pain exists in the patient. This type of illness won't show up on the regularly used imaging. This group is very different to diagnose. 1.3.8 Management of chronic pancreatitis: Pseudocysts: (it was thought that this was a problem in acute, not chronic pancreatitis). Some Pseudocysts are chronic and don't go away. It was thought that this could be a crossover questions. It was suggested that the question be edited to cover both Acute Pancreatitis and Chronic Pancreatitis. Difference in managing would depend on how ill the patient is. 1.3.9. Malabsorption and Malnutrition. Thought to be a key area for inclusion. Outcome good for patients who have had this intervention, both in terms of health and the length of their lives. Haemorrhage: Pancreatic management doesn't differ from managing haemorrgraphy in the abdomen. Not much evidence available in this area. It was thought that the identification of haemorrhage is very difficult to do. Duct obstruction: This is linked to the management of painful chronic pancreatitis. Interventions: pain corrected, pain killers, endoscopic management and surgery. Biliary obstruction: Key for benign cases. RCTs available. . This is not covered in acute pancreatitis. Some patients may have chronic pancreatitis and may have malignancies. 1.3.10 Location of follow up.

Pancreatitis: scope workshop discussions – Group 1 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
		1.3.11 Investigation during follow up. It was noted that there is little available data on these two issues. The group highlighted that there are no good screening tests. Sometimes a patient has had some pancreatic damage but they are stable. The group suggested that the best approach to a question in this area would look at: 'Is there a protocol that exists that can be agreed on in terms of time, type and frequency of follow up'. 1.3.12 Information and support. The group thought that a low population would need information
Areas that will not be covered: (page 5 line 42) 1.3.13. Diagnosis and management of pancreatic cancer 1.3.14. Diagnosis of acute pancreatitis 1.3.15. Management of gall stones 1.3.16. Management of diabetes mellitus in people with pancreatitis. 1.3.17. Lifestyle interventions. 1.3.18. Duodenal obstruction	• These are the key clinical areas that will not be included in the guideline. • Are the excluded areas appropriate? • Have any areas not been mentioned?	No input.
1.4. Economic Aspects (Page 6 line 44) An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Which practices will have the most marked/biggest cost implications for the NHS? • Are there any new practices that might save the NHS money compared to existing practice?	No input.
1.5. Key issues and questions (Page 6 line 52) This section expands upon the areas mentioned in section 1.3 of the draft scope. This section should therefore give more of the detail of what the key issues are within that area and what questions will be asked to address those issues.	<u>Management of acute pancreatitis</u> • Fluid resuscitation type – is this issue covered in the IV fluids guideline – what is different for acute pancreatitis? • Nutrition –difference from nutrition support therapy guideline is Pancreatic Enzyme Replacement Therapy - is this a large issue? • Aetiology of idiopathic recurrent acute	See above comments (section 1.3.1).

Pancreatitis: scope workshop discussions – Group 1 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
	pancreatitis – need to define question. Sequence of tests? How does management change after aetiology identified? If it doesn't then from HE perspective not cost effective to investigate. • What are the indications for referral to specialist centre? What needs managing in a specialist centre therefore how do we identify it? Why does it need to be a specialist centre? <u>Diagnosis of Chronic Pancreatitis</u> • Indicators for testing for genetic markers or auto-antibody pancreatitis – question needs defining more <u>Management of Chronic Pancreatitis</u> • Are interventions for treating fistulae different from interventions for pancreatic ascites and pleural effusion? • Haemorrhage/Gastro internal haemorrhage - if covered adequately in other GI bleeding guidance then low priority here. <u>Follow up and surveillance</u> • What investigations at follow up could be done either by GP or specialist? Or for which investigations could be done by GP which are currently done by specialists? • Is there an accurate method for diagnosis for pancreatic cancer? If not, or there is no real difference may be worth not covering the question.	
1.6. Main Outcomes (Page 8 line 110) 1.6.1. Health related quality of life 1.6.2. Mortality	• Is the list of outcomes appropriate? • Are any key outcomes missing?	The group asked the team to consider Pain as an outcome.

Pancreatitis: scope workshop discussions – Group 1 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
<u>GC Membership (This item is not included on the draft scope)</u> Full Committee Members: 1. Chair 2. Lay member 3. Lay member 4. General Practitioner 5. Nurse 6. Gastroenterologist (physician from non-specialist centre) 7. Gastroenterologist (physician from specialist centre) 8. Upper gastrointestinal surgeon (non-specialist centre) 9. Pancreatic surgeon 10. Pain specialist 11. Radiologist Cooptees 12. Anaesthetist with special interest in IV fluids 13. Geneticist	• Do you have any comments on the proposed membership of the committee?	GP input is key. It was suggested that 2 lay members was not enough as it would be good to have the acute and chronic perspectives in addition to the perspective a young person/carer. Stakeholders also suggested that a lay member bring the 'charity' perspective to the table would be helpful. The following additional roles were suggested by stakeholders: • Pancreatic Nurse/Nurse working in a specialist centre. • Acute care physicians were suggested by stakeholders, but it was felt that the Gastroenterologists could cover this perspective. • Endoscopist • Dietitian • Pediatrician • Pediatric Surgeon. • Pathologists • Critical care specialists

Further questions:	**Stakeholder responses**
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to **patient care**?	No input.
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?	No input.
3. Are there areas of **diverse or unsafe practice** or uncertainty that require addressing?	No input.
4. As a group, if you had to **rank** the issues in the Scope in order of importance what would the order be?	No input.

Further questions:	Stakeholder responses
5. Are there any areas that you think should be included for the purposes of the **quality standard**? Are there any **service delivery** or service configuration issues that you think are important?	No input.
6. Any other issues raised during subgroup discussion for noting:	No input.

Pancreatitis: scope workshop discussions – Group 2 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.1. Who is the focus: **Groups that will be covered: (Page 2 line 28)** **Children, young people and adults with acute or chronic pancreatitis** **Groups that will not be covered: (Page 2 line 30)** **Children, young people and adults with pancreatic cancer**	• The DH remit is for the diagnosis and management of pancreatitis. • Are there any specific subgroups that have not been mentioned (in either list)?	The group discussed their concerns about including paediatrics. The group heard from attending experts that treating children was not a matter of scale. Specialist pancreatic surgeons for children are quite rare. Paediatric surgeons are usually general surgeons; children need to be given special consideration. Indications for intervention, slightly different for children. Pancreatitis in children is almost always 'chronic'. As a result of metabolic disorders, treatment of other diseases, gall stones, and a small population of adolescents, from alcohol misuse. Need to address transition to adult services.
1.2. Settings **Settings that will be covered (Page 2 line 34)** 1.2.1. All settings in which NHS commissioned care is provided.	• Are the listed settings appropriate?	No comments.
1.3. Activities, services or aspects of care: **Key areas that will be covered (page 2 line 40)** 1.3.1. Fluid resuscitation for people with acute pancreatitis. 1.3.2. Use of antibiotics for people with acute pancreatitis (including both who should get them and the type of antibiotics). 1.3.3. Referral of people with acute pancreatitis. 1.3.4. Management of infected necrosis for people with acute pancreatitis. 1.3.5. Management of pancreatic ascites and pleural effusion for people with pancreatitis (acute and chronic). 1.3.6. Diagnosis of chronic pancreatitis.	• These are the key clinical areas that have been prioritised for inclusion in the guideline. • Do you think that these prioritised areas are appropriate for the topic? • Have any areas not been mentioned?	1.3.1. Fluid resuscitation. Specific studies available that address resuscitation in Pancreatitis. NCPOD review of management of acute pancreatitis. Current guidelines are not being followed. Useful as there is variance in practice. 1.3.2. Use of antibiotics: Prophylactic antibiotics have a very doubtful role. Very weak evidence for use in pancreatitis. Predominantly, patients presenting with acute pancreatitis are prescribed prophylactic antibiotics and shouldn't be. Studies show no impact. Lots of evidence available in this area. Scope for improvement. 1.3.3. Referral of people with acute pancreatitis: Referral for chronic pancreatitis also mentioned. Issues with patients not being referred to. Biggest potential impact. Huge variations in practice. 1.3.4. Management of infected necrosis for people with acute pancreatitis: There is little heterogeneity of approach in this area.

Pancreatitis: scope workshop discussions – Group 2 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.3.7. Assessment of aetiology for people with chronic pancreatitis or idiopathic recurrent acute pancreatitis. 1.3.8. Management of chronic pancreatitis, including management of: 1.3.8.1. Pseudocysts 1.3.8.2. Fistulae 1.3.8.3. Haemorrhage 1.3.8.4. Pancreatic duct obstruction 1.3.8.5. Biliary obstruction. 1.3.9. Malabsorption or malnutrition in people with chronic pancreatitis. 1.3.10. Location, frequency and investigations of follow up for people with chronic pancreatitis. 1.3.11. Surveillance for pancreatic cancer in people with chronic pancreatitis. 1.3.12. Information and support needs for people with chronic pancreatitis.		Not many District general hospitals attempt this anymore. Group felt that patient did not all have to be transferred in, but specialists could provide input. Issues in this area would be managed in large part by better practice in referral. Group suggested that 'infected' should be removed. 1.3.5. Management of pancreatic ascites and pleural effusion for people with pancreatitis (acute and chronic): Wide variation of practice, different treatments exist. Pleural effusion is not a problem in acute pancreatitis. Happens frequently, but usually resolves. Group thought this should be demoted in terms of priorities. 1.3.6. Diagnosis of chronic pancreatitis: High priority area. Diagnosis usually deferred for long period of time. This is a key area of patient concern. 1.3.7. Assessment of aetiology for people with chronic pancreatitis or idiopathic recurrent acute pancreatitis: Cause not effectively identified, so patient has frequent attacks, as cause of chronicity not addressed. High priority topic. 1.3.8. Management of chronic pancreatitis, including management of: 1.3.8.1. Pseudocysts 1.3.8.2. Fistulae 1.3.8.3. Haemorrhage 1.3.8.4. Pancreatic duct obstruction 1.3.8.5. Biliary obstruction. Group didn't think that completing systematic reviews on these rare conditions was practical. The group noted that this was a list of complications thought to be the key causes of pain in pancreatitis. The group noted that the primary cause of pain in pancreatic is the disease progress and not the secondary complications. The group noted that the management of pain in pancreatitis would not be covered by NICE existing guidelines on pain management. 1.3.9. Malabsorption or malnutrition in people with chronic pancreatitis. Key, high priority area. Potential for biggest impact to quality of life and survival. Nationally there is gross under prescribing in PERT and a lack of understanding by HCPs. Wide variation in practice in this area. 1.3.10. Location, frequency and investigations of follow up for people with chronic pancreatitis. It was mentioned, that there is an issue with patients getting discharged back to GP care. High priority area.

Pancreatitis: scope workshop discussions – Group 2 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
		1.3.11. Surveillance for pancreatic cancer in people with chronic pancreatitis. There are published international recommendations on screening for pancreatic cancer. There is a shortage of data. Potential question should cover: who should have screening and how. The group agreed that this was a priority area for inclusion. 1.3.12. Information and support needs for people with chronic pancreatitis. Large issue, however the group was concerned about where data would be sourced from. The group mentioned concerns around patients with mental capacity issues would need special condition, and so should be considered when addressing this issue. Other general suggestion; Monitoring of acute hepatitis.
Areas that will not be covered: (page 5 line 42) 1.1.1. Diagnosis and management of pancreatic cancer 1.1.2. Diagnosis of acute pancreatitis 1.1.3. Management of gall stones 1.1.4. Management of diabetes mellitus in people with pancreatitis. 1.1.5. Lifestyle interventions. 1.1.6. Duodenal obstruction	• These are the key clinical areas that will not be included in the guideline. • Are the excluded areas appropriate? • Have any areas not been mentioned?	1.1.1. Diagnosis and management of pancreatic cancer No comment/disagreement. 1.1.2. Diagnosis of acute pancreatitis. No comment/disagreement. 1.1.3. Management of gall stones No comment/disagreement. This area has a huge impact on Pancreatitis. Symptom is managed but there is under diagnosis in this area. 1.1.4. Management of diabetes mellitus in people with pancreatitis. The group thought that the management of diabetes should be included in the guideline as it was very specific to the care of pancreatitis patients. Opportunity to change current practice. Relevant to malabsorption and malnutrition issue. 1.1.5. Lifestyle interventions. Mental health was raised as a large issue, brought on by chronic pain and chronic disease. It was explained that this would not constitute a lifestyle intervention. This covers advice to patients around stopping smoking/drinking etc. 1.1.6. Duodenal obstruction No comment.
1.2. Economic Aspects (Page 6 line 44) An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic	• Which practices will have the most marked/biggest cost implications for the NHS?	No comment/disagreement.

Pancreatitis: scope workshop discussions – Group 2 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Are there any new practices that might save the NHS money compared to existing practice?	
1.3. Key issues and questions (Page 6 line 52) This section expands upon the areas mentioned in section 1.3 of the draft scope. This section should therefore give more of the detail of what the key issues are within that area and what questions will be asked to address those issues.	<u>Management of acute pancreatitis</u> • Fluid resuscitation type – is this issue covered in the IV fluids guideline – what is different for acute pancreatitis? • Nutrition –difference from nutrition support therapy guideline is Pancreatic Enzyme Replacement Therapy - is this a large issue? • Aetiology of idiopathic recurrent acute pancreatitis – need to define question. Sequence of tests? How does management change after aetiology identified? If it doesn't then from HE perspective not cost effective to investigate. • What are the indications for referral to specialist centre? What needs managing in a specialist centre therefore how do we identify it? Why does it need to be a specialist centre? <u>Diagnosis of Chronic Pancreatitis</u> • Indicators for testing for genetic markers or auto-antibody pancreatitis – question needs defining more <u>Management of Chronic Pancreatitis</u> • Are interventions for treating fistulae different from interventions for pancreatic ascites and pleural effusion? • Haemorrhage/Gastro internal haemorrhage - if covered adequately in other GI bleeding guidance then low priority here. <u>Follow up and surveillance</u> • What investigations at follow up could be done either by GP or specialist? Or	• The group was keen for a question to be asked about the management of pain. • The group mentioned that the most important thing in the management of pancreatitis is keeping the patient informed about their chronic illness. • What's the possible diagnosis that the patient is being tested for. Does the patient require PERT? It was suggested that there should be a separate question for therapies.

Pancreatitis: scope workshop discussions – Group 2 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
	for which investigations could be done by GP which are currently done by specialists? • Is there an accurate method for diagnosis for pancreatic cancer? If not, or there is no real difference may be worth not covering the question.	
1.4. Main Outcomes (Page 8 line 110) 1.4.1. Health related quality of life 1.4.2. Mortality	• Is the list of outcomes appropriate? • Are any key outcomes missing?	Not discussed.
<u>GC Membership (This item is not included on the draft scope)</u> Full Committee Members: 1. Chair 2. Lay member 3. Lay member 4. General Practitioner 5. Nurse 6. Gastroenterologist (physician from non-specialist centre) 7. Gastroenterologist (physician from specialist centre) 8. Upper gastrointestinal surgeon (non-specialist centre) 9. Pancreatic surgeon 10. Pain specialist 11. Radiologist Cooptees 12. Anaesthetist with special interest in IV fluids 13. Geneticist	• Do you have any comments on the proposed membership of the committee?	**<u>Discussed at the end of breakout sessions</u>**: GP important. Specialist nurse. Gastroenterologist that can cover acute medicine. More than one pancreatic surgeon. Endoscopist. Dietician – potentially a pancreatic dietician. Paediatrician. Lay members: - Someone who has had exposure to both acute and chronic pancreatitis. - Potentially a parent who pancreatitis and a child with pancreatitis.

Pancreatitis: scope workshop discussions – Group 2 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
		Cooptees: - Does not necessarily have to be an anaesthetist; could be critical care or interventionist with specialist interest. - Pathologist.

Pancreatitis: scope workshop discussions – Group 3 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.4. Who is the focus: **Groups that will be covered: (Page 2 line 28)** **Children, young people and adults with acute or chronic pancreatitis** **Groups that will not be covered: (Page 2 line 30)** **Children, young people and adults with pancreatic cancer**	• The DH remit is for the diagnosis and management of pancreatitis. • Are there any specific subgroups that have not been mentioned (in either list)?	No issues.
1.5. Settings **Settings that will be covered (Page 2 line 34)** 1.5.1. All settings in which NHS commissioned care is provided.	• Are the listed settings appropriate?	No issues.
1.6. Activities, services or aspects of care: **Key areas that will be covered (page 2 line 40)** 1.6.1. Fluid resuscitation for people with acute pancreatitis. 1.6.2. Use of antibiotics for people with acute pancreatitis (including both who should get them and the type of antibiotics). 1.6.3. Referral of people with acute pancreatitis. 1.6.4. Management of infected necrosis for people with acute pancreatitis. 1.6.5. Management of pancreatic ascites and pleural effusion for people with pancreatitis (acute and chronic). 1.6.6. Diagnosis of chronic pancreatitis. 1.6.7. Assessment of aetiology for people with chronic	• These are the key clinical areas that have been prioritised for inclusion in the guideline. • Do you think that these prioritised areas are appropriate for the topic? • Have any areas not been mentioned?	The group thought that the issue of management of gall stones in pancreatitis is not full covered in the gall stones guideline. The group suggested early ERCP in acute pancreatitis should be covered a potential question of 'should ERCP be done early in acute pancreatitis?' with outcomes of length of stay and complications. The group suggested the management of ascites and pleural effusion was a low priority. The group suggested that surveillance for pancreatic cancer is a low priority. The group suggested that nutritional support should be for both chronic and acute pancreatitis (enzyme replacement is a nutritional option not

Pancreatitis: scope workshop discussions – Group 3 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
pancreatitis or idiopathic recurrent acute pancreatitis. 1.6.8. Management of chronic pancreatitis, including management of: 1.6.8.1. Pseudocysts 1.6.8.2. Fistulae 1.6.8.3. Haemorrhage 1.6.8.4. Pancreatic duct obstruction 1.6.8.5. Biliary obstruction. 1.6.9. Malabsorption or malnutrition in people with chronic pancreatitis. 1.6.10. Location, frequency and investigations of follow up for people with chronic pancreatitis. 1.6.11. Surveillance for pancreatic cancer in people with chronic pancreatitis. 1.6.12. Information and support needs for people with chronic pancreatitis.		covered by the nutrition support guideline). The group thought that IV fluids should be a priority as it is specific to acute pancreatitis and not covered by the IV fluid guideline. - What fluids and how fast is key. The group thought that assessment of aetiology for people with chronic pancreatitis or idiopathic recurrent acute pancreatitis should be a high priority in the guideline but should be for all acute pancreatitis not just recurrent. - Important to find and treat the cause. - Thought that this should have an algorithm. - Thought that a key question should be: what is the optimal diagnosis method? - Suggested it should include a sequence of tests; CT, MRCP, endoscopic ultrasound, biopsy and then, if it becomes recurrent, genetic testing. The group suggested that there should be review question on the referral of people with acute pancreatitis. - What are the indications? - Should they be referred to a specialist centre if they have complications? - Centres need to be commissioned. - Sign of complications for infected necrosis are those that require intensive/secondary care. The group questioned how the guideline will cover the referral of children and those with chronic pancreatitis from a GP. They noted that this was an important issue as it is difficult for a GP to diagnose early.
Areas that will not be covered: (page 5 line 42) 1.1.7. Diagnosis and management of pancreatic cancer 1.1.8. Diagnosis of acute pancreatitis 1.1.9. Management of gall stones 1.1.10. Management of diabetes mellitus in people with pancreatitis. 1.1.11. Lifestyle interventions.	• These are the key clinical areas that will not be included in the guideline. • Are the excluded areas appropriate? • Have any areas not been mentioned?	The group thought it important that the guideline recognise the difference between diabetes and diabetes with pancreatitis. - Diabetes with pancreatitis should be recognised as a separate disease. - Interventions on a potential review question would include insulin and other drugs. The outcome would be glucose control.

Pancreatitis: scope workshop discussions – Group 3 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
1.1.12. Duodenal obstruction		The group suggested that there was a big gap in lifestyle interventions. - Suggested that nutrition should be covered in acute pancreatitis – issue of compliance. - Suggested looking at studies on cystic fibrosis.
1.2. Economic Aspects (Page 6 line 44) An economic plan will be developed that states for each review question/key area in the scope, the relevance of economic considerations, and if so, whether this area should be prioritised for economic modelling and analysis.	• Which practices will have the most marked/biggest cost implications for the NHS? • Are there any new practices that might save the NHS money compared to existing practice?	The group noted that there was a cost effectiveness study done on pancreatitis in Poland.
1.3. Key issues and questions (Page 6 line 52) This section expands upon the areas mentioned in section 1.3 of the draft scope. This section should therefore give more of the detail of what the key issues are within that area and what questions will be asked to address those issues.	<u>Management of acute pancreatitis</u> • Fluid resuscitation type – is this issue covered in the IV fluids guideline – what is different for acute pancreatitis? • Nutrition –difference from nutrition support therapy guideline is Pancreatic Enzyme Replacement Therapy - is this a large issue? • Aetiology of idiopathic recurrent acute pancreatitis – need to define question. Sequence of tests? How does management change after aetiology identified? If it doesn't then from HE perspective not cost effective to investigate. • What are the indications for referral to specialist centre? What needs managing in a specialist centre therefore how do we identify it? Why does it need to be a specialist centre? <u>Diagnosis of Chronic Pancreatitis</u> • Indicators for testing for genetic markers or auto-antibody pancreatitis – question needs defining more <u>Management of Chronic Pancreatitis</u> • Are interventions for treating fistulae different from interventions for pancreatic ascites and pleural effusion?	The group summarised that the following should be added to the scope: - Early ERCP - Diabetes in acute and chronic pancreatitis - Issue of compliance regarding nutrition. The group thought that, in the absence of a definitive cause, genetic testing applies to everyone; children, young adults and adults. - Genetic testing is also important due to pancreatic cancer screening. - Children and young adults should automatically be referred to a specialist. - There are cases of chronic pancreatitis which is not due to usual causes, such as alcohol. The group though that haemorrhage is not a high priority.

Pancreatitis: scope workshop discussions – Group 3 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
	• Haemorrhage/Gastro internal haemorrhage - if covered adequately in other GI bleeding guidance then low priority here. <u>Follow up and surveillance</u> • What investigations at follow up could be done either by GP or specialist? Or for which investigations could be done by GP which are currently done by specialists? • Is there an accurate method for diagnosis for pancreatic cancer? If not, or there is no real difference may be worth not covering the question.	
1.4. Main Outcomes (Page 8 line 110) 1.4.1. Health related quality of life 1.4.2. Mortality	• Is the list of outcomes appropriate? • Are any key outcomes missing?	
<u>GC Membership (This item is not included on the draft scope)</u> Full Committee Members: 14. Chair 15. Lay member 16. Lay member 17. General Practitioner 18. Nurse 19. Gastroenterologist (physician from non-specialist centre) 20. Gastroenterologist (physician from specialist centre) 21. Upper gastrointestinal surgeon (non-specialist centre) 22. Pancreatic surgeon 23. Pain specialist 24. Radiologist Cooptees	• Do you have any comments on the proposed membership of the committee?	GP important. Specialist nurse. Gastroenterologist that can cover acute medicine. More than one pancreatic surgeon. Endoscopist. Dietician – potentially a pancreatic dietician. Paediatrician. Lay members:

Pancreatitis: scope workshop discussions – Group 3 Date: 14 June 2016		
Scope details	**Questions for discussion**	**Stakeholder responses**
25. Anaesthetist with special interest in IV fluids 26. Geneticist		- Someone who has had exposure to both acute and chronic pancreatitis. - Potentially a parent who pancreatitis and a child with pancreatitis. Cooptees: - Does not necessarily have to be an anaesthetist; could be critical care or interventionist with specialist interest. - Pathologist.