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Opinion Article

Pediatric Autoimmune Pancreatitis (AIP) Treatment Processes

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DESCRIPTION

A kind of chronic pancreatitis known as Autoimmune Pancreatitis (AIP) is connected to autoimmune symptoms. The condition is an all-encompassing autoimmune disorder that affects not only the pancreas but also the retroperitoneum, the bile duct, and lymph nodes. Depending on the specific tissue changes found on biopsy or the predominating and accompanying symptoms, AIP is also known as lymphoplasmacytic sclerosing pancreatitis with cholangitis, idiopathic duct destructive pancreatitis, primary inflammatory pancreatitis, non-alcoholic duct destructive chronic pancreatitis, tumefactive pancreatitis, and destructive pancreatitis. As a result of substantial technical and instrumental advancements in MRI, computed tomography, and ultrasonography, autoimmune pancreatitis is no longer a rare disease but rather a clinical condition that is becoming more widely known. However, it is still challenging to distinguish between pancreatitis and small pancreatic tumors and to diagnose autoimmune pancreatitis at an early stage. Some patients with autoimmune pancreatitis could also have illnesses in other body areas. Two subgroups of AIP in adults are distinguished by differences in their epidemiology, clinical profiles, histology, natural histories, and outcomes. Asia has a high prevalence of AIP type 1 (lymphoplasmacytic sclerosing pancreatitis), but Western nations are more likely to experience AIP type 2 (idiopathic duct-centric pancreatitis). Histologic investigation is necessary for a conclusive diagnosis of idiopathic duct-centric pancreatitis, but not for lymphoplasmacytic sclerosing pancreatitis.

The adult AIP guidelines are used by pediatric gastroenterologists to identify and treat AIP in children. The clinical presentation of AIP in children differs from that in adults, according to first findings and case reports and using just adult diagnostic criteria may result in an under diagnosis of AIP in children.

The most prevalent illness that has to be distinguished from regional variants of autoimmune pancreatitis is pancreatic cancer. Differentiation from pancreatic carcinoma and normal pancreas on the basis of enhancement characteristics at dual-phase CT reported that the average CT attenuation value of the pancreatic parenchyma in autoimmune pancreatitis patients was significantly lower than that in patients with a normal pancreas. The mean CT attenuation value of the mass in autoimmune pancreatitis was not significantly different from that of carcinoma, but in the hepatic phase, the value was significantly lower.

Steroids can be used to treat the condition; surgery is not necessary. Since autoimmune pancreatitis shares many characteristics with malignancy, failing to distinguish between the two may result in needless pancreatic resection. Additionally, about one-third of patients who undergo pancreatic resection for suspected malignancy are ultimately found to have benign disease have the characteristic lymphoplasmacytic infiltrate of AIP.

The evaluation of the therapeutic effect includes changes in the following clinical signs and symptoms: 1) minimized jaundice, back and abdominal pain, 2) smaller pancreas on imaging, 3) lower levels of pancreatic enzymes, hapatobiliary enzymes, and total bilirubin, and 4) improvement in blood sugar and insulin levels. Autoimmune pancreatitis in children is becoming a more widely recognized clinical disorder. Understanding the clinical profile of AIP has advanced significantly, however the pathophysiology of AIP is still unknown. Even though the condition has been linked to numerous reports of elevated blood IgG4 levels and IgG4-positive cells in bile duct biopsy specimens, the disease's full range is not represented by the standard diagnostic criteria for autoimmune pancreatitis. Steroids can treat autoimmune pancreatitis, but it's still difficult to keep it in remission.

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