Physician jobs from the *New England Journal of Medicine* • April 2022

Insider

**Career:** What FTE is right for you? Pg. 1

**Career:** Preparing Physician CVs and Resumes for Consumption in the Digital Age. Pg. 3

**Clinical:** Chronic Pancreatitis, as published in the *New England Journal of Medicine*. Pg. 9

The latest physician jobs brought to you by the NEJM CareerCenter

Tailor Made Edition

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Dear Physician:

As a physician about to enter the workforce or in your first few years of practice, you may be assessing what kind of practice will ultimately be best for you. The New England Journal of Medicine is the leading source of information about job openings for physicians in the United States. To further aid in your career advancement, we’ve also included a couple of recent selections from our Career Resources section of NEJMCareerCenter.org.

The NEJM CareerCenter website (NEJMCareerCenter.org) continues to receive positive feedback from physicians. Because the site was designed based on advice from your colleagues, many physicians are comfortable using it for their job searches and welcome the confidentiality safeguards that keep personal information and job searches private.

At the NEJM CareerCenter, you will find:

• Hundreds of quality, current openings — not jobs that were filled months ago
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A career in medicine is challenging, and current practice leaves little time for keeping up with new information. While the New England Journal of Medicine’s commitment to delivering top-quality research and clinical content remains unchanged, we are continually developing new features and enhancements to bring you the best, most relevant information each week in a practical and clinically useful format.

A reprint of the March 3, 2022, article, “Chronic Pancreatitis,” is also included in this booklet. Our popular Clinical Practice articles offer evidence-based reviews of topics relevant to practicing physicians.

We also have audio versions of Clinical Practice articles. These are available on our website and save you time, because you can listen to the full article while at your desk, driving, or working out. Another popular feature, Videos in Clinical Medicine, enables you to watch common clinical procedures — including information about preparation and equipment — right on your desktop or mobile device. You can learn more details about these features at NEJM.org.

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On behalf of the entire New England Journal of Medicine staff, please accept my wishes for a rewarding career.

Sincerely,

Eric J. Rubin, MD, PhD

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What FTE is right for you?

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

Nobody asks for their daily schedule during medical school or residency interviews. For years during medical training, you go to work when somebody tells you to, you take as much vacation as has been allotted to you, and do the work that you’ve been assigned — and then some.

That attitude often carries over into the job search. It’s shocking how many physicians will apply to and even accept positions without a realistic picture of what a normal day in a particular job looks like. We often wear our ability to get the job done as a badge of honor, and rarely question it, not realizing that as time goes on, this is often to the detriment of our career longevity.

The fact is, “full time” for physicians is often greater than the normal 40-hour work week experienced by many other professions, and many times, “part time” for a physician doesn’t feel so part time. To state the obvious, the number of hours worked is inversely proportional to the number of hours of free time you have. While most of us derive significant personal satisfaction from our jobs, we also need time with our families and time for other activities that fill the proverbial cup.

These days, I spend a lot of time encouraging physicians to “create the life in medicine that they want,” the essence of which comes down to being more intentional about how you approach your career. Job turnover is quite common in the early years of practice, and can even lead physicians to want to exit medicine entirely. Therefore, when searching for your job, it’s imperative that in addition to all the other factors that go into the job search, the number of hours you want to work is also considered.

There are many factors that may play into this decision, including finances, debt, children, the work schedule of your significant other, interests outside of medicine, the practicalities of a specialty, and what types of positions exist. While there’s no guarantee that all of these can align perfectly, mapping out what an ideal work week looks like will allow you to tailor your job search better. At the end of the day, if you can work 30 years as a 0.8 FTE because you love it and feel that your personal and professional goals are aligned, many would choose this over working at a 1 FTE but experiencing such significant burnout that you elect to stop working as
Preparing Physician CVs and Resumes for Consumption in the Digital Age

Customization and confidentiality are key considerations in the current recruiting marketplace

By Bonnie Darves

A physician’s curriculum vitae (CV) has long functioned as a passport of sorts into the realm of potential practice opportunities, which is why physicians must make sure that the all-important document does well what it’s intended to do: provide a comprehensive but succinct and completely accurate overview of your medical training, work, and accomplishments, in a format that’s easy to read and digest. Today, however, when everything moves at, well, cyberspeed, physicians should be prepared to respond in near real time when a desirable opportunity comes up — by not only submitting a polished document but by also ensuring that the CV is tailored to the position, according to Peter Angood, MD, chief executive officer of the American Association for Physician Leadership.

“It’s important for physicians to customize their CV each time they submit it, to ensure they’re including the appropriate keywords,” Dr. Angood said, to match qualifications the organization is seeking in a candidate. “Remember that you’re trying to get through the initial screening, so the CV keywords should ideally match those in the job position.”

That screening, these days, often includes computer technology that ingests, “scrapes,” and dissects the document via machine learning, artificial intelligence, and other mechanisms to identify specific experience or specialization. Because this process typically occurs before the document is routed for human review, the CV should include keywords included in the job description, Dr. Angood said. The idea is to make sure that the physician’s qualifications “pop out” readily during both electronic and human screening. “Even in that human screening, keep in mind that the HR professional or a recruiter might only spend 30 seconds to a minute initially reviewing the CV — that’s why it should be customized,” he added.

Getting the CV through the first electronic screening hurdle is, to some extent, a numbers game, according to John Lastinger, manager of candidate experience for the national recruiting firm Merritt Hawkins. Because computer programs that match candidates with practice opportunities are primarily keyword-based, Mr. Lastinger said, the facility seeking a physician
prioritizes the skill set and experience it desires and then the system scans inbound CVs for matches to those keywords. “The more matches within the text of the CV, the higher the match rate and score, and the higher the probability the physician will be interviewed,” he said.

That’s where the specificity comes in. “Physicians should highlight all key skills and experience that fit the opportunity. For example, radiologists who are certified to read mammography should include that on their CV, as should a cardiologist who performs peripheral interventions,” Mr. Lastinger said. At the same time, he added, physicians should choose keywords judiciously and place them strategically, to avoid disseminating a document that’s obviously (and intentionally) overfilled with keywords. “We advise physicians to keep focused and be purposeful about their keyword usage,” he said.

Physicians who are very particular about where they want to practice — whether that’s a specific metro area or state, or a particular region — should also ensure they communicate that information in their CV, or in an accompanying cover note.

Brenda Reed, a senior recruitment and retention consultant at Atrius Health in Boston, said that even though computer CV screening is ubiquitous these days, physicians shouldn’t be unduly concerned that their CV will be overlooked if it doesn’t pass the computer screen. “Do organizations get so many CVs that they sort them only by bot, and not by people? I’d be truly surprised if there’s an institution that only uses bots,” Ms. Reed said. “There’s a recognition in the industry, I think, that CV parsing isn’t that advanced yet, and I’m not aware of any applicant tracking systems that do it very well.” Applicant tracking systems are software programs that organizations use to help them facilitate recruitment and hiring, by helping HR personnel and recruiters organize and navigate potentially large numbers of applicants.

Assemble a CV “package,” including a resume, in advance

Creating a polished, effective CV is the most important task for physicians seeking a practice opportunity, but that’s only the first step. All sources interviewed for this article agreed that physicians should have a complete, customizable package prepared before they start actively identifying and applying for open positions. That package, ideally, includes a CV, resume, and draft cover letter or note that can be readily adjusted to fit the opportunity, according to Dr. Angood. “I think it’s critically important to create a set of documents, and then tailor them,” he said. “There’s an ongoing need, in my experience, for physicians to appreciate the intent and purpose of these materials,” he said.

The physician resume is a short version of the CV that quickly highlights skills and qualifications for a particular position, and more importantly, provides an opportunity to briefly explain why the candidate is a good fit for the prospective position. For example, if a physician is seeking an opportunity that includes a mix of clinical and administration or leadership roles, a resume might focus the physician’s direct experience in the latter two areas. A well-structured resume that includes any business experience or credentials is a must for physicians who want to transition from clinical practice to nonclinical roles, Dr. Angood noted, and the document should also include both specific achievements — even specifics such as increasing patient volumes over time through efficiency — and a forward-looking focus or statement.

“Organizations today are looking for physicians who can demonstrate not just their experience but also how their work made an impact and how their accomplishments have prepared them to contribute to the organization they join,” Dr. Angood said, given the changing priorities of and increasing demands on hospitals and health systems today. For example, physicians who have either experience or interest in such areas as patient-centered care models, shared decisions-making, or value-based care should include those details in a resume. “Hiring organizations are very interested in knowing the opportunities and results physicians accomplished in their position,” said Dr. Angood.

Young or early-career physicians likely won’t need a resume, Ms. Reed said, unless they have obtained specific skills or experience in business, technology, or organization-wide initiatives. “Sometimes a physician applying for a patient-care opportunity might be a good candidate for an innovation position that include some nonclinical work, so that extra experience in worth noting,” she said, in either the CV or a resume.

Be selective — and careful — when using job boards to upload your CV

While physicians can likely expect a personal review of their CV when they send it directly to a hiring organization, that’s not necessarily the case when it comes to job boards. Scott Edwards, chief executive officer of Metropolis, a marketplace for health care jobs, advises physicians to be very selective when using job boards and to exercise due diligence before
creating an account and uploading their information and documents into a database.

“It’s important to check out the job board’s reputation and to ensure that you have some control over how your documents are handled. In some cases, you might upload your documents thinking that you’re applying for a particular position, when in fact you’ve simply placed your CV and personal information into a repository that all can see and that’s searchable,” said Mr. Edwards. When that happens, physicians may quickly be overwhelmed with inquiries regarding positions they’re not interested in or opportunities in unsuitable geographic areas — or possibly run the risk that their current colleagues might come across their information.

“Physicians should understand that many job boards aren’t private,” said Mr. Edwards, whose company uses a private and confidential “match” model that only connects applicants with prospective employers that have subscribed to the service and agreed to be connected if a match is found. He recommends that physicians avoid job boards that don’t allow for confidentiality or aren’t nimble enough to enable narrowing the search parameters — in terms of practice type, subspecialty, and geographic location — to only those desired.

“Physicians really should understand, before submitting their CV to a job board or repository, exactly how their materials are ingested, dissected, and disseminated once they upload it to a database,” said Ms. Reed. In short, in the persisting highly competitive, high-demand market for physician services, CVs are such hot commodities that there are technologies and software programs waiting in the wings to “snatch” the document from the internet and route it to unknown recipients.

Tips for making your CV stand out — in the right way

Be careful about how you label your CV document. Keep the recipient in mind when you create a filename, so that recruiters or others who might be reviewing candidates’ CVs can readily identify you, advises Brenda Reed, a senior recruitment and retention consultant at Massachusetts-based Atrius Health. The ideal filename would be ordered like this: Last name, first name, discipline, and specialty. “That way, reviewers can quickly figure out whose CV it is. I’ve received CVs with document names like ‘Joe’sCV.’ That makes it hard for recipients to figure out whose document it is,” Ms. Reed said. The same filename structure should also be used for the cover letter, she added.

Don’t “over-stuff” the CV. Sometimes, physicians think that because they’re trying to cover a lot of ground in a few pages, it makes sense to fill every available inch. That’s not helpful to the readers who have to make their way through a densely packed document, according to John Lastinger, manager of candidate experience for Merritt Hawkins. “White space is your friend. Make sure to leave plenty of white space,” he said, which makes it easier on readers’ eyes when they’re navigating the document. He also stresses the importance of including a name header and page number on every page of the CV, so that the document is readily identifiable. “Formatting is very important when it comes to having a document scanned, which it likely will be,” he said.

Create and submit your CV in a .pdf format rather than a .doc or other word-processing program format — and protect your personal information. The benefit of using a .pdf format is that the document can’t be readily altered by someone in the receiving chain, noted Scott Edwards, chief executive officer of Metropolis. “That might be unlikely, but it can happen if someone who is unscrupulous gains access to your CV, so it’s better to be safe,” he said. On another note, physicians who plan to submit their CVs and other materials to numerous entities and are engaging in a broad search should consider purchasing a dedicated email address specifically for their search activities. “It’s also a good idea to consider getting a dedicated cellphone number for the job search, to avoid being contacted on their personal cellphones while they’re at work,” Mr. Edwards said.

When physicians “launch” their CV, they should be prepared to respond to the flurry of inquiries that will ensue. Putting the CV out into the universe is a serious undertaking, and physicians should be ready to adjust their schedules accordingly to accommodate the responsiveness and professionalism required to manage a search, Mr. Edwards said. He recommends that physicians avoid job boards that don’t allow for parameters — in terms of practice type, subspecialty, and geographic location — to only those desired.

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Did you find this article helpful? Sign up for our Career Resources Update e-newsletter to get more physician career articles delivered right to your inbox! www.nejmcareerncenter.org/register.
A 52-year-old man reports having had two to three episodes of acute pancreatitis each year for the past 6 years. During the past 6 months, debilitating, continuous upper abdominal pain has gradually developed despite escalating treatment with meloxicam, tramadol, and, recently, oxycodone. He has three to four bulky, foul-smelling stools daily; he reports no weight loss. He has a 20-year history of alcohol use and a 25 pack-year smoking history. He has left his position at a company owing to frequent absences. Computed tomography of the abdomen reveals scattered pancreatic ductal calcifications, a dilated pancreatic duct, and an atrophic pancreas. How would you manage this case?

The Clinical Problem

Chronic pancreatitis is a progressive fibroinflammatory disease. Classic chronic pancreatitis, usually associated with alcohol use, smoking, or certain gene mutations, typically begins with recurrent painful bouts of pancreatitis, followed by the insidious development of chronic, debilitating pain during the next 3 to 5 years after an initial episode. Classic imaging findings of one or more of the triad of pancreatic ductal calcifications, ductal dilatation, and parenchymal atrophy indicate progression to chronic pancreatitis. A substantive subgroup of patients also classified as having chronic pancreatitis have neither pain (nearly 30%) nor a previous diagnosis of acute pancreatitis (approximately 50%). The primary form without pain or previous acute pancreatitis may be a different disease with a distinct pathogenesis. In practice, “chronic pancreatitis” is often used with a qualifier to describe other chronic inflammatory diseases of the pancreas (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org), which share some, but not all, of the characteristic features of classic chronic pancreatitis. This general overview is focused only on classic chronic pancreatitis in adults.

The annual incidence of chronic pancreatitis in the United States ranges from 5 to 8 per 100,000 adults, and the prevalence ranges from 42 to 73 per 100,000 adults. Risk factors include alcohol use (in 42 to 77% of patients), smoking (in >60%), and genetic mutations (in 10%); the disease is considered to be idiopathic in 28% of patients. Alcohol use (>80 g per day for 6 to 12 years) and smoking (a smoking history of >35 pack-years increases the risk of chronic pancreatitis by a factor of 5) have synergistic effects. Two thirds of patients with chronic pancreatitis are men, and risk is higher among Black persons than among White persons. Genetic mutations most commonly involve cystic fibrosis transmembrane conductance regulator (CFTR), serine protease inhibitor Kazal type 1 (SPINK1), and other genes.

References

CHRONIC PANCREATITIS
- Chronic pancreatitis, which is commonly associated with alcohol use, smoking, or genetic risk factors, often manifests as recurrent bouts of abdominal pain or pancreatitis. Characteristic imaging findings include pancreatic stones, dilated ducts, and atrophy.
- Complications of chronic pancreatitis include pseudocysts, biliary strictures, exacerbation of pancreatic insufficiency, and recurrence of pancreatic cancer; there is currently no effective early detection strategy for pancreatic cancer.
- Exocrine insufficiency causing steatorrhea leads to weight loss, sarcopenia, and deficiencies of fat-soluble vitamins and other micronutrients and is mitigated by treatment with pancreatic-enzyme replacement.
- Strategies for managing chronic abdominal pain include medical therapies (analogic agents, limited use of narcotics, antioxidants, and neuromodulators), endoscopic treatment (pancreatic stenting with or without extracorporeal shockwave lithotripsy), and surgical interventions (duct drainage and resection procedures), as well as behavioral interventions for centrally mediated pain.

EVALUATION AND DIAGNOSIS
Evaluation for chronic pancreatitis and its complications includes a careful clinical history taking, laboratory testing, and imaging. Histologic analysis (Fig. S1) is not needed for diagnosis and is not often available; definitive diagnosis rests heavily on imaging findings. Laboratory testing includes assessment of pancreatic endocrine function (screening for diabetes mellitus) and exocrine function (described below).

IMAGING
Imaging methods include computerized tomography (CT) (Fig. 1), magnetic resonance cholangiopancreatoscopy (MRCP), and endoscopic ultrasonography (EUS); endoscopic retrograde cholangiopancreatography (ERCP); and magnetic resonance imaging of the pancreas (MRI). Of these, CT is the most expensive than CT or MRI, is unsuitable for patients with allergy to contrast media and deficiency of vitamin D and osteopenia or osteoporosis, with bone pain and low-impact fractures.7,8 Chronic pancreatitis is associated with increased mortality from any cause, owing to complications and the availability of noninvasive imaging.7 Of these, CT is the most readily available and widely used. In a large meta-analysis, the sensitivity and specificity of CT, magnetic resonance imaging (MRI), and EUS did not differ significantly,11 but EUS is invasive, observer-dependent, and prone to false-positive results.8

MRCP, especially after secretin stimulation, has the advantages of better delineation of the pancreatic and bile ducts, the absence of radiation, and safety in patients with allergy to contrast media or with renal insufficiency with the use of noncontrast T2-weighted sequences. However, MRCP takes longer and is more expensive than CT or MRI, is unsuitable for patients with claustrophobia, and can miss calcification.3

Other Evaluations
Abnormality of multiple domains (Tables 1 and 2) is warranted, including the nature and severity of upper abdominal pain, imaging findings, nutritional status, substance abuse, disability due to disease, resilience and motivation for behavioral change, and effect of the disease on psychosocial function. Pancreatic exocrine function is evaluated by history taking and laboratory testing. Individual symptoms (abdominal pain, diarrhea, and fatty, foul-smelling, difficult-to-pass stools with weight loss), suggestive symptoms, and a serum elastase level of less than 50 μg per gram of stool or low micronutrient levels, or a fecal fat level of 15 g or more per day.1 The Malnutrition Universal Screening Tool calculator can be used to establish nutritional risk with the use of other objective measurements of height and weight to obtain a score and a risk category or subjective criteria to estimate a risk category but not a score. The “Timed Up and Go (TUG)” instrument can be used for assessing fall risk (https://www.cdc.gov/steadi/pdf/TUG_test-print.pdf).

† Interventions include strength training and nutritional supplementation.

‡ Treatment with pancreatic-enzyme replacement is appropriate if one or more of the following is present: classic symptoms of steatorrhea (bloating, foul-smelling, difficult-to-passage stools with weight loss), suggestive symptoms, and a fecal elastase level of less than 50 μg per gram of stool or low micronutrient levels, or a fecal fat level of 15 g or more per day.1 The Malnutrition Universal Screening Tool calculator can be used to establish nutritional risk with the use of either objective measurements of height and weight to obtain a score and a risk category or subjective criteria to estimate a risk category but not a score. The “Timed Up and Go (TUG)” instrument can be used for assessing fall risk (https://www.cdc.gov/steadi/pdf/TUG_test-print.pdf).

Pancreatic exocrine function

<table>
<thead>
<tr>
<th>Symptoms of steatorrhea</th>
<th>Classic symptoms, suggestive but not diagnostic symptoms, or no symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecal elastase level</td>
<td>Generally &lt;50 μg per gram of stool in stage III or IV</td>
</tr>
<tr>
<td>Fecal fat test over period of 48 or 72 hr</td>
<td>&gt;7 g per day in stage III or IV</td>
</tr>
<tr>
<td>Serum fat-soluble vitamins (A and E) and other micronutrients (zinc, magnesium, and vitamin B₁₂)</td>
<td>Vitamin and micronutrient deficiency: present or absent</td>
</tr>
<tr>
<td>Malnutrition: hand grip, body-mass index, unplanned weight loss, and bone density</td>
<td>Muscle wasting (none, mild, moderate, or severe), muscle strength (normal or impaired), and osteoporosis or osteopenia: present or absent</td>
</tr>
</tbody>
</table>

Table 1. Suggested Assessments for Impairments in Biophysical Domains.

Domain and Assessment

Pain: duration since onset, intermittent or continuous, frequency of flares, severity during and between flares on visual analogue scale, documentation of pancreatitis during flares (serum lipase or imaging evidence), relationship of pain to activities such as eating and exercise, responses to treatments, and use and frequency of narcotics and side effects (constipation, blunting, and increased pain)

Pain patterns: type A is intermittent attacks of pain or pancreatitis without intervening pain for which narcotics are not used (type B₁), for which narcotics are used for ≤6 mo (type B₂), or for which narcotics are used for >6 mo (type B₃) (centrally mediated abdominal pain syndrome); and type C is continuous narcotic-treated pain for >6 mo without intermittent attacks of pain or acute pancreatitis or complications (centrally mediated abdominal pain syndrome)
quantitative fecal fat measured in stool collected over a period of 48 to 72 hours while the patient follows a diet containing 100 g of fat daily. Measurement of the fecal elastase level is simple, inexpensive, and widely available. Levels below 200 μg per gram of stool are considered to be abnormal, but only very low values (≤50 μg per gram or even <15 μg per gram, according to one report) are reasonably predictive of steatorrhea. Abnormal levels above 50 μg per gram occur in many other conditions, including diabetes, old age, irritable bowel syndrome, inflammatory bowel disease, renal failure, functional dyspepsia, and any watery diarrhea and have poor specificity for steatorrhea. The frequent mischaracterization of any abnormality in fecal elastase levels as pancreatic insufficiency has led to overdiagnosis and overtreatment. Quantitative fecal fat testing is available through many academic centers and major reference laboratories in the United States. Challenges to its routine use include patient adherence to the recommended diet, complete stool collection, and cumbersome manual laboratory testing and analysis. With proper instructions and adherence to the 100-g fat diet for 2 days before and throughout the stool-collection period, fecal fat testing provides the best estimate of digestive capacity. A normal value for the coefficient of fat absorption is at least 93%, and a normal amount of fat in stool is less than 7 g per 24 hours; elevated values occur in disorders of absorption and digestion. In routine clinical practice, a fecal elastase test can be performed annually as a screening test for pancreatic exocrine insufficiency. A fecal fat test should be performed to confirm pancreatic insufficiency if fecal elastase levels or vitamin A or E levels are very low in the absence of the classic complex of symptoms of steatorrhea.

**Management**

Indications for treatment in patients with chronic pancreatitis are pain, complications, and functional (endocrine and exocrine) insufficiency. Treatment options are described below.

**Pain**

Management of pain in patients with chronic pancreatitis has traditionally relied on the biophysical model of health and disease, which posits that all symptoms have a structural basis. However, recognition of central sensitization and the role of psychological and social factors associated with chronic pain support expansion of management approaches to include attention to nonstructural behavioral interventions.

**Table 2. Suggested Assessments and Interventions for Impairments in Psychosocial Domains.**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Assessment†</th>
<th>Categorization</th>
<th>Intervention‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability due to disease</td>
<td>Functional impairment at home, work, school, or in other social areas</td>
<td>Disability: none, mild, moderate, severe, or extreme</td>
<td>Options include cognitive behavioral therapy, resilience training, and formal pain rehabilitation programs</td>
</tr>
<tr>
<td>Substance use disorders</td>
<td>Use of tobacco, alcohol, prescription medication, and other substances</td>
<td>Addiction: present or absent; if present, to which substances</td>
<td>Encourage patient to seek help from addiction clinics</td>
</tr>
<tr>
<td>Resilience</td>
<td>Ability to bounce back from setbacks</td>
<td>Resilience: low, normal, or high</td>
<td>If resilience is impaired, recommend referral to stress management and resilience training program</td>
</tr>
<tr>
<td>Motivation</td>
<td>Motivation to initiate or maintain behavior changes</td>
<td>Motivation: low (not interested), moderate (skeptical but willing to engage), or high (believes in and wants help)</td>
<td>For type B or C pain patterns, introduce patients to and encourage participation in nonstructural interventions</td>
</tr>
<tr>
<td>Social support</td>
<td>Quality of social relationships</td>
<td>Social support: low, moderate, or high</td>
<td>If social support is low, refer patient to social worker</td>
</tr>
</tbody>
</table>

*A Assessments can be performed at bedside in all patients, especially those with pain patterns type B and C. Validated questionnaires include (TAPS) Tool19; Brief Resilience Scale20; Motivation and Attitudes toward Changing Health (MATCH) scale21; and Multidimensional Scale of Perceived Social Support22.

† The integrated (holistic) management of patients with impairments in multiple biophysical and psychosocial domains may require referral to tertiary care centers.

‡ There is no effective medical treatment to stop the recurrence of acute pancreatitis. For acute and chronic pain, medical therapies include analgesic agents, antidopaminergic and neurokinin antagonists (e.g., gabapentinoids and tricyclic antidepresants) and opioids. Regular use of opioids should be avoided owing to risks of tolerance, addiction, narcotic bowel syndrome, and a paradoxical increase in pain due to opioid-induced hyperalgesia. Two meta-analyses of randomized trials of various commercially available antidopaminergic combinations (vortioxetine, amitriptyline, duloxetine, and nefazodone) and gabapentinoids showed significant reductions in the number of days with pain and in narcotic use. There is no effective medical treatment to stop the recurrence of acute pancreatitis. For acute and chronic pain, medical therapies include analgesic agents, antidopaminergic and neurokinin antagonists (e.g., gabapentinoids and tricyclic antidepresants) and opioids. 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Pain procedures: celiac plexus block, spinal cord stimulation, and acupuncture

<table>
<thead>
<tr>
<th>Pain pattern</th>
<th>Psychosocial impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A: Intermittent, infrequent attacks of pain or pancreatitis</td>
<td>Establish physician–patient rapport</td>
</tr>
<tr>
<td>Type B: Intermittent severe pain with continuous pain between attacks</td>
<td>Assess biophysical and psychosocial impairments</td>
</tr>
<tr>
<td>Type C: Severe, constant pain without attacks of pain or pancreatitis</td>
<td>Structural intervention based on imaging (consider structural intervention in infrequent attacks [≥1 yr apart])</td>
</tr>
</tbody>
</table>

Structural intervention (endoscopic and structural) based on imaging for pain warranting narcotics is generally warranted; pain relief is reported in more than 70% of patients. Endoscopic management is also indicated for some complications of chronic pancreatitis (e.g., pseudocysts and pancreatic ascites).

**Surgery**
Options for surgery for pain relief include pancreatic resection for persistent focal inflammation (standard pancreaticoduodenectomy and its variants or distal pancreatectomy), drainage of an obstructed duct (longitudinal pancreaticojejunostomy and its variants), or a combination of both (Frey procedure). Autologous islet-cell transplantation (Fig. 1).

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Indications</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics: NSAIDs, tramadol, and opioids</td>
<td>Initial treatment</td>
<td>Use WHO pain ladder (for mild pain, nonopioid analgesics; for moderate pain, weak opioids, and for severe pain, potent opioids with nonopioid agents, the adjuts listed below, or both); consider alternate interventions if opioids are used continuously.</td>
</tr>
<tr>
<td>Neurmodulators</td>
<td>Within months after narcotic use, neuropathic pain</td>
<td>Can be used along with structural therapies; pregabalin superior to placebo in randomized, controlled trials; gabapentin and selective epi-nephrine or norepinephrine reuptake inhibitors also recommended by experts.</td>
</tr>
<tr>
<td>Antioxidants: vitamins A, C, and E, selenium, and methionine</td>
<td>At any stage to reduce painful attacks as well as days with pain</td>
<td>Reduced pain in meta-analyses of randomized trials of supplements (although trials were small, and one showed no benefit); randomized trial showed benefit in combination with neurmodulators; can be combined with any intervention; generally given as fixed-dose combinations; increased intake from dietary sources may be encouraged but has not been formally studied.</td>
</tr>
<tr>
<td>Treatment with pancreatic-enzyme replacement</td>
<td>Reduce bloating, cramping, and borborygmi</td>
<td>Meta-analyses show no benefit for pain relief.</td>
</tr>
<tr>
<td>Pain procedures: celiac plexus block, spinal cord stimulation, and acupuncture</td>
<td>Neuropathic pain, usually after endoscopic and surgical interventions, if no relief</td>
<td>Evidence limited for acupuncture, spinal cord stimulation, and celiac plexus block.</td>
</tr>
<tr>
<td>Addiction treatment, counseling, and psychosocial interventions (cognitive behavioral therapy, stress management and resilience training, and pain rehabilitation)</td>
<td>Neuropathic pain, along with or after endoscopic or surgical interventions</td>
<td>Abstinence from alcohol may protect against recurrence of attacks, slow deterioration of pancreatic function, and reduce mortality; randomized, controlled trial showed benefit of Internet-based cognitive behavioral therapy for chronic pain and useful for motivated patients, especially those with clinically significant disability from disease, addictions, or poor resilience.</td>
</tr>
</tbody>
</table>

**Exocrine Pancreatic Insufficiency**
Treatment with pancreatic-enzyme replacement mitigates the effects of steatorrhea. It is indicated if a patient has one or more of the following: classic symptoms of steatorrhea; suggestive but not diagnostic symptoms plus a fecal elastase level of less than 50 μg per gram of stool or low microminute levels; or a fecal fat level of 15 g.

**Table 3. Interventions for Chronic Pancreatitis.**

*NSAIDs denotes nonsteroidal antiinflammatory drugs, and WHO World Health Organization.*
The relationship between exocrine and endocrine dysfunction (type 3c diabetes) in chronic pancreatitis and the role of newer diabetes therapies in treating type 3c diabetes are uncertain. Larger and longer-term trials are needed to better assess pharmacological, behavioral, and structural interventions for chronic pain (particularly neuropathic type) associated with chronic pancreatitis. Several guidelines have been published in the past 5 years (Table S2), some involving overall evaluation and management and others focused on specific aspects of the disease. The recommendations in this article are generally consistent with these guidelines, except that guidelines have not addressed the evaluation and management of psychosocial domains contributing to chronic pain. Further study is needed of strategies for early detection of chronic pancreatitis, prevention of recurrent pancreatitis and its progression, identification and assessment of centralized medullary chronic neuropathic pain, identification of pancreatic cancer-related diabetes (type 3c) as compared with other causes of diabetes, and early detection of pancreatic cancer. The natural history of chronic pancreatitis is not well understood but is currently being studied in a prospective cohort study in the United States (Prospective Evaluation of Chronic Pancreatitis for Epidemiologic and Translational Studies [PROCEED]).

GUIDELINES

The patient in the vignette has chronic pancreatitis associated with alcohol use, with both centrally mediated and pain-related pancreatitis (type B2). His history also suggests exocrine pancreas insufficiency: confirmation with evela estest or fecal fat testing is recommend ed. We would assess levels of fat-soluble vitamins, zinc, magnesium, vitamin B12, and glycated hemoglobin and consider baseline dual-energy x-ray absorptiometry. If pancreatic insufficiency is confirmed, we would treat with pancreatic-enzyme replacement and a balanced diet supplemented with fat-soluble vitamins and micronutrients and with normal fat content. Structural as well as nonstructural interventions will probably be necessary. Given the presence of stones of more than 5 mm in diameter, extraduodenal shockwave lithotripsy would be appropriate along with endoscopic retrograde cholangiopancreatography or endoscopic pancreatic duct is present to correct the fragments, with a plan for surgical intervention if pain persists. For further management of ongoing pain, we would recommend pregabalin along with referral to a pain rehabilitation program, where available, including cognitive behavioral therapy. Counseling regarding alcohol, nicotine, and narcotic use, stress management, and racial identity training are important. Periodic follow-up, initially at intervals of 6 months or 1 year, will be needed to evaluate the effectiveness of treatment and disease progression.

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