

Test Specific Guidelines

Hereditary Pancreatitis Genetic Testing

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Introduction

Genetic testing for hereditary pancreatitis is addressed by this guideline.

Procedures Addressed

The inclusion of any procedure code in this table is provided for informational purposes and is not a guarantee of coverage nor an indication that prior authorization is required.

<u>Procedures addressed by this guideline</u>	<u>Procedure codes</u>
<u>CFTR Deletion/Duplication Analysis</u>	<u>81222</u>
<u>CFTR Known Familial Mutation Analysis</u>	<u>81221</u>
<u>CFTR Sequencing</u>	<u>81223</u>
<u>CFTR Targeted Mutation Analysis</u>	<u>81479</u>
<u>Hereditary Pancreatitis Gene Analysis</u>	<u>81400</u>
	<u>81401</u>
	<u>81402</u>
	<u>81403</u>
	<u>81404</u>
	<u>81405</u>
	<u>81406</u>
	<u>81407</u>
	<u>81408</u>
	<u>81479</u>
<u>Hereditary Pancreatitis Multigene Panel</u>	<u>81479</u>

What Is Pancreatitis?

Definition

Pancreatitis is inflammation of the pancreas that may be acute, acute recurrent, or chronic.¹

Prevalence

PRSS1 mutations are identified in 5-7% of individuals with chronic pancreatitis.²
In one US study of children, PRSS1 mutations were identified in 46% of those diagnosed with chronic pancreatitis and 17% of those with recurrent acute pancreatitis.²

Symptoms

Acute pancreatitis is defined as two of the three following findings:²

Abdominal pain

Elevated serum amylase or lipase (greater than 3x the upper limit of normal)

Findings consistent with pancreatic inflammation on abdominal imaging.

Acute recurrent pancreatitis is defined as multiple (2 or more), discrete episodes of acute pancreatitis without any evidence of chronic pancreatitis.² There must be complete resolution of clinical and laboratory findings between episodes.

Chronic pancreatitis (CP) is a pathologic fibro-inflammatory syndrome of the pancreas in individuals with genetic, environmental and/or other risk factors who develop persistent pathologic responses to parenchymal injury or stress.³

Common features of established and advanced CP include:

Pancreatic exocrine dysfunction

Pancreatic endocrine dysfunction and dysplasia.

Up to 5% of patients with chronic pancreatitis may develop pancreatic cancer.⁴

The efficacy of pancreatic cancer screening has not been proven, and this screening is typically recommended to take place in a research setting.⁴

Cause

Idiopathic sporadic pancreatitis occurs when a single individual in a family is affected, and the etiology is unknown despite comprehensive investigations.

Familial pancreatitis is pancreatitis of any cause (genetic or non-genetic) that occurs in a family with a greater incidence than would be expected by chance alone.¹

Hereditary pancreatitis (HP) is a rare cause of acute, acute recurrent, and chronic pancreatitis. It is defined as a personal history of pancreatitis and pancreatitis diagnosed in two first-degree relatives or in three second degree relatives spanning at least two generations. Beginning with the first report of a PRSS1 mutation in a family with HP, it has been shown that multiple genetic risk factors are associated with this disease.⁵

Mutations in the following genes contribute to the development of acute recurrent and chronic pancreatitis:¹

PRSS1 mutations are the most common cause of hereditary pancreatitis.^{1,2} Mutations in this gene follow autosomal dominant inheritance and have a penetrance of approximately 80%.

The mutation detection rate for PRSS1 sequencing is approximately 94%, and deletion/duplication analysis is at least 6%.² N29I (p.Asn29Ile) and R122H (p.Arg122His) variants account for approximately 90% of cases of pathogenic variants observed in PRSS1-related HP.² Test results particularly for the PRSS1 gene, may offer prognostic information since the risk of pancreatic cancer in those with chronic pancreatitis is significantly increased.

SPINK1 mutations may increase the severity of acute recurrent and chronic pancreatitis due to mutations in PRSS1, CFTR, CASR, or CTRC.^{1,6} The majority of SPINK1 mutations are sequence variants, with deletions having been reported in a very small number of cases.¹

CFTR mutations are risk factors for pancreatitis. Individuals with biallelic CFTR mutations may have atypical cystic fibrosis (CF), putting them at risk for additional manifestations such as lung disease, male infertility, and chronic sinusitis.¹ The frequency of CFTR deletions in HP has not been investigated; however they occur rarely in cystic fibrosis (approximately 1%).¹

CTRC mutations have been identified in individuals with acute recurrent and chronic pancreatitis. These variants were initially thought to be modifier genes, however they have been shown to be sufficient to cause disease without other identifiable genetic or environmental risk factors.⁷

CASR mutations may be a predisposing genetic factor for pancreatitis either in isolation or as modifying risk when other genetic causes are present.⁸

CLDN2, CPA1, and GGT1 variants have been implicated as risk factors or modifiers for chronic pancreatitis, but less is known about the utility of screening for these mutations compared to the others mentioned above.^{1,8}

TRPV6 mutations have been reported in patients with early-onset CP not associated with alcohol consumption.¹ In a recent study, 20% patients with functionally defective TRPV6 variants also had the SPINK1 p.N34S variant.⁹

CEL and PNLIP variants may result in an increased risk of developing pancreatitis as mutations in these genes are enriched in chronic pancreatitis patient populations. However, current data remains limited and the clinical utility of screening for these genetic variants is uncertain.^{1,9}

Rare disorders that include pancreatitis/pancreatic insufficiency as part of a more complex syndrome include Schwachman-Diamond syndrome (SBDS).

mitochondrial DNA deletions, CEL-associated maturity-onset diabetes of the young (MODY), and Johanson-Blizzard syndrome (UBR1).¹

Genes included on hereditary pancreatitis multi-gene panels may not be causative or associated with high risk for pancreatitis (e.g.: CLDN2).¹

Inheritance

While single pathogenic variants in SPINK1, CFTR, and CTSC are associated with an increased risk of acute recurrent or chronic pancreatitis, additional unidentified modifying factors may contribute to the disease.¹ These include alcohol use, smoking, chronic kidney disease, autoimmune factors, and anatomic issues.¹ Individuals with multiple risk factors (including multiple gene mutations) have a higher risk for pancreatitis.¹

Biallelic variants of SPINK1 have been reported to result in early onset pancreatitis, suggesting an autosomal recessive pattern of inheritance with reduced penetrance.¹

The rare disorders of which pancreatitis is a feature have varying patterns of inheritance.

Diagnosis

Pancreatitis is diagnosed by one of the following:¹⁻³

Abdominal imaging

Functional studies (e.g. pancreatic exocrine insufficiency or pancreatic endocrine insufficiency with diabetes mellitus)

Histology

Genetic testing results provide important early information about the etiology of pancreatitis-related disorders.³ Determining the etiology of a pancreatitis-related disorder may not lead to immediate treatment in some cases, but it often ends exhaustive, invasive, and expensive diagnostic testing for advanced disease. Understanding the genetic etiology also informs decisions about therapy for persistent or severe disease, such as total pancreatectomy with islet autotransplantation.³ However, genetic testing cannot predict the age of onset or disease severity.^{1,4}

Management

Treatment of HP focuses on longitudinal monitoring of endocrine and exocrine pancreatic function, enzyme and nutritional supplementation, pain management and monitoring for complications (such as decreased bone mineral density and fat-soluble vitamin deficiencies). Endoscopic and surgical therapies may be

necessary in some cases. Affected individuals are discouraged from smoking and drinking alcohol.¹

Survival

In a relatively small study of PRSS1 mutation carriers, overall survival did not differ significantly from that of the general US Caucasian population.¹⁰ Pancreatic cancer rates were higher and contributed to mortality.

Test Information

Introduction

Testing for hereditary pancreatitis may include known familial mutation analysis, next generation sequencing, and/or multigene panel testing.

Known Familial Mutation (KFM) Testing

Known familial mutations analysis is performed when a causative mutation has been identified in a close biological relative of the individual requesting testing. Analysis for known familial mutations typically includes only the single mutation. However, if available, a targeted mutation panel that includes the familial mutation may be performed.

Next Generation Sequencing Assay

Next generation sequencing (NGS), which is also sometimes called massively parallel sequencing, was developed in 2005 to allow larger scale and more efficient gene sequencing. NGS relies on sequencing many copies of small pieces of DNA simultaneously and using bioinformatics to assemble the sequence. Sequence analysis detects single nucleotide substitutions and small (several nucleotide) deletions and insertions. Regions analyzed typically include the coding sequence and intron/exon boundaries. Promoter regions and intronic sequences may also be sequenced if disease-causing mutations are known to occur in these regions of a gene.

Multi-Gene Testing Panels

The efficiency of NGS has led to an increasing number of large, multi-gene testing panels. NGS panels that test several genes at once are particularly well-suited to conditions caused by more than one gene or where there is considerable clinical overlap between conditions making it difficult to reliably narrow down likely causes. Additionally, tests should be chosen to maximize the likelihood of identifying mutations in the genes of interest, contribute to alterations in patient management, and/or minimize the chance of finding variants of uncertain clinical significance.

Guidelines and Evidence

Introduction

The following section includes relevant guidelines and evidence pertaining to

genetic testing for hereditary pancreatitis.

American College of Gastroenterology

The American College of Gastroenterology (ACG, 2013) guideline on management of acute pancreatitis stated: “Genetic testing may be considered in young patients (<30 years old) if no cause is evident and a family history of pancreatic disease is present (conditional recommendation, low quality of evidence).”¹¹

The ACG (2015) guidelines on genetic testing for hereditary gastrointestinal cancer syndromes stated that having a history of hereditary pancreatitis is a risk factor for familial pancreatic adenocarcinoma, and genetic testing for pancreatitis-associated genes should be considered for pancreatic cancer patients with “a personal history of at least 2 acute attacks of acute pancreatitis of unknown etiology, a family history of pancreatitis, or early-age onset chronic pancreatitis.”¹²

The ACG (2020) guideline on chronic pancreatitis recommended genetic testing in patients with clinical evidence of a pancreatitis-associated disorder or possible CP in which the etiology is unclear, especially in younger patients.²

American Pancreatic Association

American Pancreatic Association (APA, 2014) guidelines stated: “Several genetic variations have been associated with pancreatitis including PRSS1, PRSS2, SPINK1, CTRC, CASR and CFTR. The role of these gene mutations in CP is becoming increasingly recognized and better understood.” It is also noted that “knowledge of gene, gene-environment interactions may translate into new diagnostic and treatment paradigms” (Strong recommendation, level of evidence – moderate).¹³

Fourth International Symposium of Inherited Diseases of the Pancreas

The Fourth International Symposium of Inherited Diseases of the Pancreas (2007) recommended symptomatic patients be referred for genetic counseling to consider PRSS1 testing when at least one of the following conditions are met, in order to determine if they may be candidates for pancreatic cancer surveillance:¹⁴

“≥2 attacks of acute pancreatitis of unknown aetiology”

“Idiopathic chronic pancreatitis, particularly if disease onset occurs <25 years of age”

“One first-degree or second-degree relative with pancreatitis”

“Unexplained documented episode of childhood pancreatitis that required hospitalization and where there is concern that HP should be excluded.”

“Asymptomatic people should be referred for genetic counseling to consider testing for a PRSS1 mutation when the patient has one first-degree relative with a defined HP gene mutation.”

United European Gastroenterology

United European Gastroenterology (UEG, 2018) guidelines on chronic pancreatitis stated:¹⁵

“A diagnosis of cystic fibrosis needs to be ruled out in all patients with CP onset before the age of 20 years as well as in patients with so-called ‘idiopathic’ CP (regardless of the age of onset). (GRADE 1B, strong agreement)”

“All patients with a family history or early onset disease (less than 20 years) should be offered genetic testing for associated variants. (GRADE 2C, strong agreement)”

“Genetic testing was recommended to include PRSS1, SPINK1, CPA1, CTFR, CEL, and “may include screening for variants in CFTR. (GRADE 2C, strong agreement)”

Select Relevant Publications

2007 Expert Authored Review

A 2007 expert-authored guideline on non-syndromic pancreatitis stated genetic testing should be considered when an affected patient fulfills at least one of the following criteria:¹⁶

“A family history of recurrent acute pancreatitis, idiopathic chronic pancreatitis, or childhood pancreatitis without a known cause”

“Relatives known to carry mutations associated with pancreatitis”

“A series of recurrent acute attacks of pancreatitis for which there is no other explanation”

“An unexplained documented episode of pancreatitis as a child”

“Idiopathic chronic pancreatitis (especially when onset of pancreatitis precedes age 25)”

“Patients eligible for approved research protocols”

“[...] symptomatic family members at risk of inheriting a PRSS1 mutation may wish to be tested after a mutation has been identified in the family...Testing asymptomatic individuals for CFTR and SPINK1 mutations is not recommended because a large fraction of those who carry mutations in these genes never develop pancreatitis. CFTR carrier testing should be offered to unaffected relatives of a CFTR mutation that is capable of causing classic CF.”

2007 Expert Authored Review

A 2007 expert-authored review on hereditary pancreatitis recommended PRSS1 and SPINK1 mutation testing in symptomatic patients with one of the following:¹⁷

“recurrent unexplained attacks of acute pancreatitis and positive family history”

“unexplained chronic pancreatitis and a positive family history”

“unexplained chronic pancreatitis without a positive family history after exclusion of other causes”

“unexplained pancreatitis episode in children”

2010 Expert Authored Review

A 2010 expert-authored review on genetic testing in pancreatitis stated:¹⁸

“Because of the high penetrance (80%) of the more common PRSS1 mutations, especially R112H and N29I, testing is generally accepted for diagnostic purposes in symptomatic individuals. The confirmation of a genetic etiology of pancreatitis provides a valid explanation for both symptoms and/or disease, and may be helpful to predict a lack of efficacy with various endoscopic or operative procedures.”

“[T]here is currently no clinical indication for the routine use of SPINK1 mutation testing for either diagnostic or screening purposes and has no implications in altering the management of patients with pancreatitis.”

“[T]he CTSC gene that is the most recently identified pancreatitis susceptibility gene, should be approached in a similar fashion to SPINK1 as it is also associated with a very low penetrance.”

Regarding testing for CFTR mutations, “In subjects presenting with pancreatitis, the overwhelming rationale for further testing is to exclude or confirm the diagnosis of CF [cystic fibrosis]. The traditional sweat test remains the primary diagnostic test for CF disease in the genomic age. In any symptomatic individual, diagnostic testing should include sweat testing as the primary test and referral to a CF clinic made if sweat chloride concentration is borderline (40-59 mmol/L) or abnormal (>60 mmol/L). CFTR mutation analysis in isolation, as the first-line clinical diagnostic test, is unlikely to change management but may instead give false reassurance of the absence of CF if CFTR genotyping fails to identify mutations or alternatively be inappropriately thought to be diagnostic of CF... [T]here is currently no rationale for CFTR mutation screening for risk of pancreatitis alone.”

2016 Expert Authored Review

A 2016 expert-authored review on hereditary pancreatitis stated:¹⁹

“[...] targeted genetic testing of members of an established HP family may be considered in cases of unexplained [recurrent acute pancreatitis] and/or [chronic pancreatitis], an affected individual with a first or second-degree relative with pancreatitis, unexplained pancreatitis in a child requiring hospitalization and/or when there is a known mutation in the family.”

“[...] next generation sequencing approaches such as whole exome sequencing or whole genome sequencing should not be used for PRSS1 testing because of challenges in sequence alignment. If a mutation is not identified from sequencing or targeted mutation analysis, deletion/duplication analysis can be considered.”

“In families where a deleterious variant has been identified, predictive genetic testing may be considered in close family members...Genetic testing of asymptomatic family members in a family without an identifiable mutation is uninformative.”

“Genetic testing may be indicated in a child with diagnosed or suspected pancreatitis...Predictive genetic testing for asymptomatic patients less than 16 years of age is not recommended and does not have clear benefits.”

2017 Expert Authored Review

A 2017 expert authored review on pediatric acute recurrent and chronic pancreatitis concluded:²⁰

“The search for a genetic cause of ARP or CP should include a sweat chloride test (even if newborn screening for cystic fibrosis (CF) is negative) and PRSS1 gene mutation testing. Genetic testing for CF should be considered if a sweat test is unable to be performed.” (Strong consensus, definitely yes, 1A)

“Mutation analysis of the genes SPINK1, CFTR and CTSC may identify risk factors for ARP or CP.” (Strong consensus, definitely yes, 1B)

2020 Expert Authored Review

A 2020 expert-authored review on pancreatitis recommended molecular genetic testing in a proband with pancreatitis and at least of one of the following:¹

“An unexplained documented episode of acute pancreatitis in childhood”

“Recurrent acute attacks of pancreatitis of unknown cause”

“Chronic pancreatitis of unknown cause, particularly with onset before age 35 years without a history of heavy alcohol use (>5 drinks per day)”

“A history of at least one relative with recurrent acute pancreatitis, chronic pancreatitis of unknown cause, or childhood pancreatitis of unknown cause”

PRSS1 sequencing is recommended, followed by deletion/duplication analysis if sequencing is negative. Alternatively, a multi-gene panel that includes PRSS1, SPINK1, CFTR, and CTSC may be appropriate.

Criteria

Introduction

Requests for genetic testing for hereditary pancreatitis are reviewed using the following criteria.

Known Familial Mutation Analysis

Genetic Counseling:

Pre and post-test genetic counseling by an appropriate provider (as deemed by the Health Plan policy), AND

Previous Genetic Testing:

No previous genetic testing that would detect the familial mutation, and

Pathogenic pancreatitis-associated mutation(s) in a 1st degree biologic relative, AND

Diagnostic Testing in Symptomatic Individuals:

Member is symptomatic (at least one documented episode of acute pancreatitis or a diagnosis of acute recurrent or chronic pancreatitis), OR

Predisposition Testing for Presymptomatic/Asymptomatic Individuals:

Age 16 years or older

PRSS1 Analysis

Genetic Counseling:

Pre and post-test genetic counseling by an appropriate provider (as deemed by the Health Plan policy), AND

Previous Testing:

No previous PRSS1 analysis, AND

Diagnostic Testing for Symptomatic Individuals:

An unexplained, documented episode of acute pancreatitis in an individual less than 18 years of age, or

Acute recurrent pancreatitis (2 or more documented episodes) or chronic pancreatitis, and

Symptom onset prior to age 25 years, and/or

A first degree biologic relative with recurrent acute pancreatitis, idiopathic chronic pancreatitis, or childhood pancreatitis (less than 18 years of age) without a known cause, and

No known etiology for the member's pancreatitis (e.g. alcoholism, gallstones, known genetic disorder), and

Absence of extra-pancreatic features suggestive of a complex genetic syndrome or cystic fibrosis (e.g. chronic sinopulmonary disease, failure-to-thrive, obstructive azoospermia due to congenital absence of the vas deferens, etc.), AND

Rendering laboratory is a qualified provider of service per the Health Plan policy.

Pancreatitis Multi-Gene Panel

When a multi-gene panel is being requested and will be billed with the appropriate CPT panel code, the panel will be considered medically necessary when the following criteria are met:

Genetic Counseling:

Pre and post-test genetic counseling by an appropriate provider (as deemed by the Health Plan policy), AND

Previous Testing:

No previous multi-gene analysis, and

PRSS1 analysis, if previously performed, was negative, AND

Diagnostic Testing for Symptomatic Individuals:

An unexplained, documented episode of acute pancreatitis in an individual less than 18 years of age, or

Acute recurrent pancreatitis (2 or more documented episodes) or chronic pancreatitis, and

Symptom onset prior to age 25 years, or

A first degree biologic relative with recurrent acute pancreatitis, idiopathic chronic pancreatitis, or childhood pancreatitis (less than 18 years of age) without a known cause, and

No known etiology for the member's pancreatitis (e.g., alcoholism, gallstones, known genetic disorder), and

Absence of extra-pancreatic features suggestive of a complex genetic syndrome or cystic fibrosis (e.g., chronic sinopulmonary disease, failure-to-thrive, obstructive azoospermia due to congenital absence of the vas deferens, etc.), AND

Rendering laboratory is a qualified provider of service per the Health Plan policy.

CLDN2, PNLIP, and CEL Analysis

These tests are considered investigational and/or experimental.

Investigational and experimental (I&E) molecular and genomic (MolGen) tests refer to assays involving chromosomes, DNA, RNA, or gene products that have insufficient data to determine the net health impact, which typically means there is insufficient data to support that a test accurately assesses the outcome of interest (analytical and clinical validity), significantly improves health outcomes (clinical utility), and/or performs better than an existing standard of care medical management option. Such tests are also not generally accepted as standard of care in the evaluation or management of a particular condition.

In the case of MolGen testing, FDA clearance is not a reliable standard given the number of laboratory developed tests that currently fall outside of FDA oversight and FDA clearance often does not assess clinical utility.

Billing and Reimbursement Considerations

When separate procedure codes will be billed for individual pancreatitis-associated genes (e.g., Tier 1 MoPath codes 81200-81355 or Tier 2 MoPath codes 81400-81408), the entire panel will be approved if the above criteria are met. However, the laboratory will be redirected to the use of an appropriate panel CPT code for billing purposes.

The billed amount should not exceed the list price of the test.

Broad gastrointestinal disease panels may not be medically necessary when a narrower panel is available and more appropriate based on the clinical findings.

Genetic testing is only necessary once per lifetime. Therefore, a single gene included in a panel or a multi-gene panel may not be reimbursed if testing has been performed previously. Exceptions may be considered if technical advances in testing demonstrate significant advantages that would support a medical need to retest.

If a panel was previously performed and an updated, larger panel is being requested, only testing for the medically necessary, previously untested genes will be reimbursable. Therefore, only the most appropriate procedure codes for those additional genes will be considered for reimbursement.

If the laboratory will not accept redirection to a panel code, the medical necessity of each billed component procedure will be assessed independently.

In general, only a limited number of panel components that are most likely to explain the member's presentation will be reimbursable. The remaining panel components will not be reimbursable.

When the test is billed with multiple stacked codes, only the following genes may be considered for reimbursement in a tiered fashion:

PRSS1

SPINK1

CFTR

CTRC

:

Note This guideline addresses testing for non-syndromic hereditary pancreatitis. For information on testing for syndromes that may include pancreatitis as part of a more complex phenotype (e.g. Schwachman-Diamond syndrome, CEL-related MODY, mitochondrial disorders, Johanson-Blizzard syndrome) please refer to appropriate guidelines (e.g. *Maturity-Onset Diabetes of the Young (MODY) Genetic Testing* or *Mitochondrial Disorders Genetic Testing*) or applicable clinical

use guidelines, if available. For information on CFTR analysis for individuals suspected of having Cystic Fibrosis please refer to the guideline *Cystic Fibrosis Testing*, as this is not addressed here.

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