Introduction

Acute pancreatitis (AP) is an inflammatory disease of pancreas of highly variable severity, ranging from mild cases with low mortality to severe cases with high mortality. Initial clinical assessment alone identifies fewer than half the patients with severe AP (SAP).[8] The initial incidence of AP ranges from 5 to 30 per 100,000 population.[3,4] Gallstones and alcohol are the two main causes of AP. Approximately 50–70% of AP cases are caused by gallstones.[3,4] Increasing age, male gender, and lower socio-economic class are associated with a higher incidence of AP.[5]

Scoring systems incorporating clinical, biochemical, or radiological criteria for severity assessment have been in use for more than a decade. These include the criteria described by Ranson (11 criteria) in the 1970s, the Glasgow score (8 criteria),[3,6] and the Acute Physiology and Chronic Health Evaluation (APACHE II) score (14 criteria).[7] The sensitivity and specificity of these scoring systems for predicting SAP range between 55% and 90%, depending on the cutoff number and the timing of scoring.[8] The predictive value of these scoring systems is improved by the addition of information provided by abdominal computed tomography (CT). Balthazar[9] developed a CT severity index (CTSI), with an index of ≥7 having a 92% positive predictive value for a severe course of AP. If done on day 4 following symptom onset, the sensitivity for detecting pancreatic necrosis was 100%.

Severity of the disease is classified as mild, moderate, and severe by the absence or presence of organ failure and local or systemic complications as described in the Modified Atlanta classification. Moderately SAP has transient organ failure of <2 days or 48 h, whereas SAP is defined by the presence of persistent organ failure for ≥2 days or 48 h. Although the revised Atlanta classification of AP is simple and will help the clinician to predict the outcomes of patients with AP, it is unable to differentiate between moderately SAP and SAP before 48–72 h after onset. Due to this shortfall among these scoring systems, a less complex method is required to predict severity and outcome of AP earlier.
which clinicians can use bedside. Serum amylase and lipase, the standard tests for AP diagnosis, are poor predictors of severity. Markers for the early prediction of AP severity include the pancreatic pro-enzyme trypsinogen-2 and its subunit trypsinogen activation peptide, as well as early inflammatory response markers such as serum interleukin (IL)-6, procalcitonin, polymorphonuclear elastase, and serum amyloid A. The more established marker C-reactive protein (CRP) has been shown to be a severity predictor at 48 h post-symptom onset if a cutoff level of 150 mg/dL is being used. Single laboratory markers for predicting the severity of AP have been investigated, but promising initial results have not always been confirmed in later studies. This study was done to assess the role of serum IL-6 and serum CRP in early prediction of severity of AP.

**Aim and objectives**

Role of serum IL-6 and CRP in early prediction of SAP is by:
(a) correlating the serum levels of IL-6 and CRP on days 1 and 2 in cases of AP with revised Atlanta classification and (b) correlating the levels of IL-6 and CRP with modified CTSI.

**Materials and Methods**

This observational analytical study was conducted in the Department of General Surgery and Department of Biochemistry, ESI-PGIMSR and Model Hospital, New Delhi, India, after obtaining permission from the Institutional Ethical Committee for a period of 2 years.

**Sample size**

Using the formula for observational study

\[
N = \frac{Z^2_{\alpha/2}pq}{d^2} ,
\]

where \(Z\) is the ordinate of standard normal distribution at \(\alpha\)% level of significance, and \(p\) is the observed sensitivity.

\[q = 1 - p,\]

\(d\) is the margin of error.

Assuming \((p)=80\%\) as the sensitivity from previous studies with 10% margin of error, the minimum required sample size at 5% level of significance is 62 patients.

**Inclusion criteria**

- Age group >18 and <70 years (both male and female)
- All patients attended emergency/OPD with diagnosis or diagnosed as case of AP
- Patients willing to participate in the study

**Exclusion criteria**

- Patients with chronic liver disease
- History of liver abscess <3 months

- Recurrent AP <3 months
- Chronic pancreatitis (± calcific)
- Severe cardiac disease
- Pregnancy

Along with all routine examination and investigations, tests that were specific to this study were done as follows:

- Serum CRP on days 1 and 2;
- Serum IL-6 on days 1 and 2;
- Contrast-enhanced computed tomography abdomen had been done on day 5 in all the patients and at the end of 4th week in unresolved cases only.

These patients were diagnosed based on clinical features and serum amylase and lipase levels. In patients with confirmed diagnosis of AP, assessment of severity of AP was done as per the revised Atlanta Classification and modified CTSI.

**Observations and Results**

**Age**

The mean age of the patients in the study was 39.21 ± 12.43 years. Most of the patients, i.e., 29.03%, were in the age group 31–40 years, whereas 24.19% of the patients were in the age group 41–50 years and 19.35% of the patients were in the age group 21–30 years, with few patients less than 20 years (5) and >50 years (12).

**Gender**

In this study, 45.16% (28) were females and 54.84% (34) were males.

**Aetiology**

Gall stone was the cause in majority [42 (67.74%)] of the patients, followed by alcohol in 11 (17.74%) and idiopathic dilated cardiomyopathy in 9 (14.52%) patients.

**Severity of pancreatitis**

According to the revised Atlanta classification, majority (64.52%) of the patients were categorized as mild AP and 35.48% of the patients were categorized as SAP.

According to the modified CTSI, majority (53.23%) of the patients were categorized as moderate AP followed by 30.65% of patients as SAP and 16.13% of patients as mild AP. Mean value of the modified CTSI of study subjects was 5.13 ± 2.53 [Table 1].

**Complication/sequelae/mortality**

In this study, complications were seen in 38.71% (24) patients. Pleural effusion was found in 18 (29.03%) patients followed by necrosis in 14 (22.58%) patients. However, seven (11.29%) patients had ascites, and very few, i.e., four patients had multi-organ dysfunction syndrome (MODS) and pseudocyst was found in only three patients. In this study, 4 out of 62 patients died due to MODS.
**IL-6 and CRP**

The mean value of CRP on day 1 was $8.27 \pm 5.88$ mg/dL which was significantly decreased to $6.35 \pm 4.91$ mg/dL on day 2. A significant decrease was seen in the values of IL-6 from day 1 ($271.87 \pm 675.94$ pg/mL) to day 2 ($102.13 \pm 111.36$ pg/mL) [Table 2].

Significant association exists between IL-6 levels and CRP levels on day 1 and day 2 with severity according to the revised Atlanta classification. IL-6 levels and CRP levels on day 1 and day 2 were significantly higher in patients categorized as SAP by the revised Atlanta classification when compared with patients categorized as mild AP. IL-6 levels on day 1 and day 2 were $74 \pm 40.4$ and $41.35 \pm 27.94$ pg/mL in patients with SAP when compared with CRP being $631.62 \pm 105.45$ and $212.63 \pm 121.43$ pg/mL on day 1 and day 2, respectively. CRP levels on day 1 and day 2 were $4.88 \pm 2.9$ and $3.51 \pm 2.47$ mg/dL, respectively, in patients with SAP when compared with patients with mild AP having CRP levels to be $14.44 \pm 4.82$ and $11.52 \pm 3.88$ mg/dL on day 1 and day 2, respectively, by the revised Atlanta classification [Table 3 and Figure 1].

The value of amylase in patients categorized as SAP was $913.73 \pm 601.19$ U/L and in mild AP it was $636.95 \pm 313.3$ U/L. Though the value of amylase was higher in severe when compared with mild AP, the difference was not statistically significant. Therefore, no significant association was seen between amylase and severity, according to the revised Atlanta classification ($P>0.05$).

Value of lipase as well as duration of hospital stay was significantly higher in patients categorized as SAP by the revised Atlanta classification when compared with patients categorized as mild AP ($P<0.05$).

A significant association exists between IL-6 levels and CRP levels on days 1 and 2 with the modified CTSI. IL-6 and CRP levels on days 1 and 2 were significantly higher in patients categorized as SAP by the modified CTSI when compared with patients categorized as mild and moderate AP; the value of amylase and lipase was higher in SAP when compared with mild and moderate AP, and the difference was not statistically significant. No significant association was seen between amylase and lipase with severity according to the modified CTSI ($P>0.05$).

Duration of hospital stay was significantly higher in patients categorized as SAP when compared with patients categorized as mild and moderate AP ($P<0.05$) [Table 3 and Figure 2].

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**Table 1: Severity according to the revised Atlanta classification and modified CT severity index**

| Severity according to | Revised Atlanta Classification | Modified CTSI |
|-----------------------|-------------------------------|---------------|
|                       | Mild | Severe | Total | Mild | Moderate | Severe |
| Frequency             | 40   | 22     | 62    | 10   | 33        | 19     |
| Percentage            | 64.52| 35.48  | 100.00| 16.13| 53.23     | 30.65  |

| Mean ± Std dev | Median (IQR) | P-value |
|----------------|--------------|---------|
| CRP (mg/dL) day 1 | 8.27 ± 5.88 | 6.58 (3.750–12.170) | <0.0001 |
| CRP (mg/dL) day 2 | 6.35 ± 4.91 | 4.21 (2.400–10.120) | <0.0001 |
| Interleukin-6 (pg/mL) day 1 | 271.87 ± 675.94 | 99.85 (54.700–182.400) | <0.0001 |
| Interleukin-6 (pg/mL) day 2 | 102.13 ± 111.36 | 63.75 (28.300–127.300) | <0.0001 |

**Table 2: Comparison of IL-6 and CRP of study subjects between day 1 and day 2**

| IL-6 and CRP | Mean ± Std dev | Median (IQR) | P-value |
|--------------|----------------|--------------|---------|
| CRP (mg/dL) day 1 | 4.88 ± 2.9 | 4.42 (3.305–6.235) | <0.0001 |
| CRP (mg/dL) day 2 | 3.51 ± 2.47 | 3.1 (1.925–4.120) | <0.0001 |
| Interleukin-6 (pg/mL) day 1 | 636.95 ± 313.3 | 913.73 ± 601.19 | 0.089 |
| Interleukin-6 (pg/mL) day 2 | 977.38 ± 545.79 | 1605.41 ± 1474.52 | 0.026 |
| Serum amylase (U/L) | 7.7 ± 1.83 | 14.04 ± 2.24 | <0.0001 |
| Lipase (U/L) | 7 (6.500–9) | 13.5 (13–16) | <0.0001 |

**Table 3: Association of severity according to the revised Atlanta classification with IL-6, CRP, amylase, lipase, and hospital days**

| Association table | Severity according to revised Atlanta classification | P-value |
|-------------------|-----------------------------------------------|---------|
|                   | Mild (n=40) | Severe (n=22) |
| Mean ± Std dev   | Median (IQR) | Mean ± Std dev   | Median (IQR) |
| Interleukin-6 (pg/mL) day 1 | 74 ± 40.4 | 75.9 (47.800–98.050) | 631.62 ± 1055.45 | 270.6 (179.600–564.300) | <0.0001 |
| Interleukin-6 (pg/mL) day 2 | 41.35 ± 27.94 | 34.35 (18.950–54.600) | 212.63 ± 121.43 | 159.1 (124.400–293.100) | <0.0001 |
| CRP (mg/dL) day 1 | 4.88 ± 2.9 | 4.42 (3.305–6.235) | 14.44 ± 4.82 | 13.78 (11.400–16.100) | <0.0001 |
| CRP (mg/dL) day 2 | 3.51 ± 2.47 | 3.1 (1.925–4.120) | 11.52 ± 3.88 | 10.94 (9.670–12.300) | <0.0001 |
| Serum amylase (U/L) | 636.95 ± 313.3 | 913.73 ± 601.19 | 646 (528–1196) | 0.089 |
| Lipase (U/L) | 977.38 ± 545.79 | 1605.41 ± 1474.52 | 1149 (928–1662) | 0.026 |
| Hospital stay (days) | 7.7 ± 1.83 | 14.04 ± 2.24 | 13.5 (13–16) | <0.0001 |
A significant positive correlation exists between CRP levels on day 1 and day 2 and IL-6 levels on day 1 and day 2, with modified CTSI with correlation coefficients of 0.771, 0.792, 0.863, and 0.852, respectively.

A significant positive correlation exists between CRP levels on day 1 and day 2 and IL-6 levels on day 1 and day 2 with hospital days with correlation coefficient of 0.671, 0.644, 0.787, and 0.788, respectively [Table 4 and Figure 2].

Fair significant agreement exists between modified CTSI and severity according to the revised Atlanta classification with a kappa value of 0.324, as shown in Table 5 and Figure 2.

Interpretation of the area under the receiver operating characteristic (ROC) curve showed that the performance of IL-6 on day 1, IL-6 on day 2, CRP on day 1, and CRP on day 2 was excellent [area under the curve (AUC) 0.968; 95% confidence interval (CI): 0.889–0.996, AUC 0.984; 95% CI: 0.914–1.000, AUC 0.923; 95% CI: 0.826–0.975, and AUC 0.935; 95% CI: 0.842–0.982, respectively] for predicting SAP. There is always a trade-off between sensitivity and specificity (any increase in sensitivity will be accompanied by a decrease in specificity). A cutoff point at which the combination of both sensitivity and specificity gives the maximum predictive value was derived from our findings. Cutoff point of IL-6 on day 1, IL-6 on day 2, CRP on day 1, and CRP on day 2 were 632, 977, 914, and 1605, respectively.
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1, and CRP on day 2 for predicting SAP was 137, 77.3, 9.6, and 5.6, respectively. IL-6 on day 2 had a maximum AUC of 0.984 and so was the best predictor of SAP [Table 6].

IL-6 on day 1 and day 2 and CRP on day 2 were 100% sensitive, but IL-6 on day 1 and day 2 had a maximum specificity of 88.37% among them when compared with a specificity of 81.4% of CRP on day 2. CRP on day 1 had a specificity of 88.37% and a sensitivity of 89.47% [Table 7].

Discussion
In this study, a significant positive correlation was found between CRP levels on day 1 and day 2 and IL-6 levels on day 1 and day 2 with duration of hospital stay. Kolber et al., in their study, also found that IL-6 and CRP concentrations were positively correlated with the length of hospital stay, i.e., patients with higher CRP and IL-6 value have severe pancreatitis and require prolonged hospitalization and even ICU stay is required in most of them. High morbidity and mortality in severe AP contributed to longer hospital stay. Value of lipase and duration of hospital stay were significantly higher in patients categorized as SAP by the revised Atlanta classification when compared with patients categorized as mild AP [Table 3].

Four out of 62 (6.45%) patients died due to SAP. In this study, the major cause of death observed was MODS. Mann et al. and Banerjee et al. separately noted that in

| Table 4: Correlation of CRP and IL-6 with hospital days and modified CT severity index |
|-----------------------------------------|-----------------|-----------------|
| Correlation table                      | Hospital stay   | Modified CT severity index |
| CRP (mg/dL) day 1                      | Correlation coefficient | 0.671 | 0.771 |
|                                        | P-value         | <0.0001         | <0.0001 |
|                                        | n               | 62              | 62     |
| CRP (mg/dL) day 2                      | Correlation coefficient | 0.644 | 0.792 |
|                                        | P-value         | <0.0001         | <0.0001 |
|                                        | n               | 62              | 62     |
| Interleukin-6 (pg/mL) day 1            | Correlation coefficient | 0.787 | 0.863 |
|                                        | P-value         | <0.0001         | <0.0001 |
|                                        | n               | 62              | 62     |
| Interleukin-6 (pg/mL) day 2            | Correlation coefficient | 0.788 | 0.852 |
|                                        | P-value         | <0.0001         | <0.0001 |
|                                        | n               | 62              | 62     |

| Table 5: Inter-rater kappa agreement of modified CT severity index and severity according to the revised Atlanta classification |
|----------------------------------------------------------------------------------------------------------------------------------|
| Modified CT severity index | Severity according to revised Atlanta classification | Total (n=62) | P-value | Kappa |
|---------------------------|------------------------------------------------------|-------------|---------|-------|
| Mild                       | Mild (n=40)                                           | 10 (16.13%) | 0 (0.00%) | 10 (16.13%) | <0.0001 | 0.324 |
| Moderate                  | Moderate (n=30)                                       | 30 (48.39%) | 3 (4.84%) | 33 (53.23%) | <0.0001 | 0.773 |
| Severe                    | Severe (n=22)                                        | 0 (0.00%)   | 19 (30.65%) | 19 (30.65%) | <0.0001 | 0.568 |
| Total                     | Total (n=62)                                         | 40 (64.52%) | 22 (35.48%) | 62 (100.00%) |         |       |

| Table 6: Receiver operating characteristic curve for predicting severe acute pancreatitis |
|------------------------------------------|--------------|-------------|
| Prediction of severe acute pancreatitis  | Area under the ROC curve (AUC) | Standard error | 95% Confidence interval | P-value | Cutoff |
| Interleukin-6 (pg/mL) day 1              | 0.968        | 0.0203      | 0.889–0.996 | <0.0001 | >137  |
| Interleukin-6 (pg/mL) day 2              | 0.984        | 0.011       | 0.914–1.000 | <0.0001 | >77.3 |
| CRP (mg/dL) day 1                        | 0.923        | 0.0329      | 0.826–0.975 | <0.0001 | >9.6  |
| CRP (mg/dL) day 2                        | 0.935        | 0.0292      | 0.842–0.982 | <0.0001 | >5.6  |

| Table 7: Diagnostic test of IL-6 and CRP for predicting severe acute pancreatitis |
|------------------------------------------|---------------|-------------|------------------|--------------|------------------|
| Diagnostic test                          | Sensitivity (95% CI) | Specificity (95% CI) | Positive predictive value (95% CI) | Negative predictive value (95% CI) | Cutoff |
| Interleukin-6 (pg/mL) day 1              | 100% (82.4–100) | 88.37% (74.9–96.1) | 79.2% (57.8–92.9) | 100% (90.7–100) |
| Interleukin-6 (pg/mL) day 2              | 100% (82.4–100) | 88.37% (74.9–96.1) | 79.2% (57.8–92.9) | 100% (90.7–100) |
| CRP (mg/dL) day 1                        | 89.47% (66.9–98.7) | 88.37% (74.9–96.1) | 77.3% (54.6–92.2) | 95% (83.1–99.4) |
| CRP (mg/dL) day 2                        | 100% (82.4–100) | 81.4% (66.6–91.6) | 70.4% (49.8–86.2) | 100% (90–100) |
In the present study, IL-6 levels were found to be significantly higher on day 1 and day 2 in AP [Table 8]. The levels of IL-6 were found to be significantly higher in severe AP cases when compared with mild/moderate AP cases [Table 8]. The levels of IL-6 decreased significantly on day 2 of AP and the decrease was found to be significant. In the present study, a cutoff value of IL-6 >137 pg/mL on day 1 and a cutoff value of >77.3 pg/mL on day 2 showed a sensitivity and specificity of 100% and 88.4%, respectively. However in the study by Gurda-Duda et al., the sensitivity and specificity of serum CRP at admission in detecting the severity of AP were found to be 63.6% and 65.5%, respectively.

In this study, a similar positive association of IL-6 and CRP with Atlanta classification was observed by Rao and Kunte. However, Agarwal et al. found that no correlation exists between IL-6 level and CTSI. Interpretation of the area under the ROC curve showed that the performance of IL-6 on day 1, IL-6 on day 2, CRP on day 1, and CRP on day 2 was excellent for predicting SAP. IL-6 on day 2 had a maximum AUC of 0.984 and so was the best predictor of SAP.

A significant positive correlation was found between IL-6 and CRP levels on day 1 and day 2, with correlation coefficients of 0.734 and 0.712, respectively, in our study. Similar results were found in the study of Goral and Berekatoglu Mete. In response to tissue injury, IL-6 is produced promptly but transiently and it contributes to host defense through stimulation of acute phase response, immune responses, and hematopoiesis. After synthesis at the local level, IL-6 moves to liver through blood stream where it induces acute phase protein such as CRP and serum amyloid A.

In the present study, CRP levels on day 1 and day 2 were significantly higher in AP [Table 8]. The levels of CRP were found to be significantly higher in SAP when compared with mild/moderate AP cases [Table 8]. In the present study, the cutoff value of CRP >9.6 mg/dL on day 1 showed a sensitivity and a specificity of 89.4% and 88.37%, respectively, and the cut-off value of CRP >5.6 mg/dL on day 2 showed a sensitivity and specificity of 100% and 81.4%, respectively. However in the study by Gurda-Duda et al., the sensitivity and specificity of serum CRP at admission in detecting the severity of AP were found to be 63.6% and 65.5%, respectively.

In another study by Sathyanarayan et al., a significant positive correlation was found between IL-6 and CRP levels on day 1 and day 2, with correlation coefficients of 0.734 and 0.712, respectively, in our study. Similar results were found in the study of Goral and Berekatoglu Mete. In response to tissue injury, IL-6 is produced promptly but transiently and it contributes to host defense through stimulation of acute phase response, immune responses, and hematopoiesis. After synthesis at the local level, IL-6 moves to liver through blood stream where it induces acute phase protein such as CRP and serum amyloid A.

In another study by Sathyanarayan et al., it was found that the level of IL-6 was significantly higher in patients who develop organ failure compared with those who did not show a sensitivity and specificity of 81.8% and 77.7%, respectively.

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A significant association was seen between IL-6 levels and CRP levels on day 1 and day 2 with severity, according to the revised Atlanta classification and modified CTSI. A similar positive association of IL-6 and CRP with Atlanta classification was observed by Rao and Kunte. However, Agarwal et al. found that no correlation exists between IL-6 level and CTSI. Interpretation of the area under the ROC curve showed that the performance of IL-6 on day 1, IL-6 on day 2, CRP on day 1, and CRP on day 2 was excellent for predicting SAP. IL-6 on day 2 had a maximum AUC of 0.984 and so was the best predictor of SAP.

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Overall, serum IL-6 and CRP were more sensitive and specific in determining severity of AP.

**Conclusion**

IL-6 on day 1 and day 2 and CRP on day 2 were 100% sensitive, but IL-6 on day 1 and day 2 had a maximum specificity of 88.37% among them, when compared with a specificity of 81.4% of CRP on day 2. Though CRP on day 1 had a specificity of 88.37%, its sensitivity was 89.47%.

| Table 8: Association of modified CT severity index with IL-6, CRP, amylase, lipase, and hospital days |
| Association table | Mild (n=10) | Moderate (n=33) | Severe (n=19) | P-value |
|-------------------|------------|----------------|--------------|---------|
| Interleukin-6 (pg/mL) day 1 Mean ± Std dev | 43.9 ± 42.05 | 102.76 ± 82.35 | 685.56 ± 1128.48 | <0.0001 |
| Interleukin-6 (pg/mL) day 2 Mean ± Std dev | 25.78 ± 18 | 52.54 ± 34.54 | 228.42 ± 123.14 | <0.0001 |
| CRP (mg/dL) day 1 Mean ± Std dev | 3.73 ± 2.53 | 6.15 ± 3.99 | 14.36 ± 5.19 | <0.0001 |
| CRP (mg/dL) day 2 Mean ± Std dev | 2.26 ± 1.54 | 4.54 ± 3.19 | 11.65 ± 4.15 | <0.0001 |
| Serum amylase (U/L) Mean ± Std dev | 642.8 ± 356.64 | 621.33 ± 294.29 | 981.47 ± 620.2 | 0.08 |
| Hospital stay (days) Mean ± Std dev | 6.4 ± 1.26 | 8.39 ± 1.97 | 14.53 ± 1.9 | <0.0001 |

AP the average mortality rate approaches 2–10%, whereas Steinberg and Tenner noted a mortality of 2–9% in their study.

In this study, majority (53.23%) of the patients were categorized as moderate AP followed by 30.65% as SAP and 16.13% as mild AP according to the modified CTSI, whereas according to the revised Atlanta classification, majority (64.52%) of the patients were categorized as mild AP and 35.48% were categorized as SAP. A fair significant correlation was noted between the modified CTSI and severity according to the revised Atlanta classification with a kappa value of 0.324 [Table 5].

In the present study, IL-6 levels were found to be significantly higher on day 1 and day 2 in AP [Table 8]. The levels of IL-6 were found to be significantly higher in severe AP cases when compared with mild/moderate AP cases [Table 8]. The levels of IL-6 decreased significantly on day 2 of AP and the decrease was found to be significant. In the present study, a cutoff value of IL-6 >137 pg/mL on day 1 and a cutoff value of >77.3 pg/mL on day 2 showed a sensitivity and specificity of 100% and 88.4%, respectively. However in the study by Gurda-Duda et al., the sensitivity and specificity of serum CRP at admission in detecting the severity of AP were found to be 63.6% and 65.5%, respectively.

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Overall, serum IL-6 and CRP were more sensitive and specific in determining severity of AP.
The ROC curve showed that the performance of IL-6 on day 1, IL-6 on day 2, CRP on day 1, and CRP on day 2 was excellent for predicting SAP. IL-6 on day 2 had a maximum AUC of 0.984 and so was the best early predictor of SAP.

IL-6 and CRP together appear to be promising markers for assessing the severity of AP within 48 h. We recommend doing IL-6 and CRP in cases of pancreatitis which can help in predicting the severity of the disease in patients and hence timely intensive management can be done.

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Conflicts of interest
There are no conflicts of interest.

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