	Criterion	Level 1	Level 2
P	Parenchymal imaging	Typical: Diffuse enlargement with delayed enhancement (sometimes associated with rim-like enhancement)	Indeterminate (including atypical[†]): Segmental/focal enlargement with delayed enhancement
D	Ductal imaging (ERP)	Long (>1/3 length of the main pancreatic duct) or multiple strictures without marked upstream dilatation	Segmental/focal narrowing without marked upstream dilatation (duct size, <5 mm)
S	Serology	IgG4, >2× upper limit of normal value	IgG4, 1–2× upper limit of normal value
OOI	Other organ involvement	a or b	a or b
		a. Histology of extrapancreatic organs Any three of the following: (1) Marked lymphoplasmacytic infiltration with fibrosis and without granulocytic infiltration (2) Storiform fibrosis (3) Obliterative phlebitis (4) Abundant (>10 cells/HPF) IgG4-positive cells	a. Histology of extrapancreatic organs including endoscopic biopsies of bile duct[‡]: Both of the following: (1) Marked lymphoplasmacytic infiltration without granulocytic infiltration (2) Abundant (>10 cells/HPF) IgG4-positive cells
		b. Typical radiological evidence At least one of the following: (1) Segmental/multiple proximal (hilar/intrahepatic) or proximal and distal bile duct stricture (2) Retroperitoneal fibrosis	b. Physical or radiological evidence At least one of the following: (1) Symmetrically enlarged salivary/lachrymal glands (2) Radiological evidence of renal involvement described in association with AIP
H	Histology of the pancreas	LPSP (core biopsy/resection) At least 3 of the following: (1) Periductal lymphoplasmacytic infiltrate without granulocytic infiltration (2) Obliterative phlebitis (3) Storiform fibrosis (4) Abundant (>10 cells/HPF) IgG4-positive cells	LPSP (core biopsy) Any 2 of the following: (1) Periductal lymphoplasmacytic infiltrate without granulocytic infiltration (2) Obliterative phlebitis (3) Storiform fibrosis (4) Abundant (>10 cells/HPF) IgG4-positive cells
		Diagnostic steroid trial	
Response to steroid (Rt)*		Rapid (≤2 wk) radiologically demonstrable resolution or marked improvement in pancreatic/extrapancreatic manifestations	

*Diagnostic steroid trial should be conducted carefully by pancreatologists with caveats (see text) only after negative workup for cancer including endoscopic ultrasound-guided fine needle aspiration.

[†]Atypical: Some AIP cases may show low-density mass, pancreatic ductal dilatation, or distal atrophy. Such atypical imaging findings in patients with obstructive jaundice and/or pancreatic mass are highly suggestive of pancreatic cancer. Such patients should be managed as pancreatic cancer unless there is strong collateral evidence for AIP, and a thorough workup for cancer is negative (see algorithm).

[‡]Endoscopic biopsy of duodenal papilla is a useful adjunctive method because ampulla often is involved pathologically in AIP.