Editorial

Is “Observation” the Single Method of Treatment for Post-Pancreatoduodenectomy Complications Due to the Strictured Anastomosis? -

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The stricture of pancreateoenteric anastomotic site is one of the problematic late complications after pancreatoduodenectomy (PD) [1]. Almost all patients with this disorder are asymptomatic, but roughly 2% of these patients suffer from acute recurrent pancreatitis (ARP) [2,3], which requires repeated hospitalization and negatively impacts patients’ quality of life (QOL). Acute pancreatitis is induced by pancreatic juice flow obstruction due to the strictured anastomosis. Another relatively common complication of post-pancreatoduodenectomy is pancreatic fistula (PF), which occurs early after pancreatoduodenectomy in 10-20% of the patients [2,3]. This disorder also affects the QOL of patients due to continuous percutaneous drainage of pancreatic juice, and is sometimes responsible for mortality [4]. Stricture of pancreateo-digestive tract anastomosis is also experienced with PF [5,6]. Surgical procedures to remove the strictured anastomosis [1] have been performed for relief of those complications. However, surgeons sometimes hesitate an additional operation due to a susceptible postoperative adhesion or a physical burden to the patients. Just inhibiting per oral intake with intravenous hyperelementation, percutaneously external drainage for peripancreatic fluid collection have been selected to treat these complications. Usually, it takes much time to resolve them, and compels patients to stay in a hospital for long period.

Recently, endoscopic treatment has gathered attention to treat these complications [7-12]. Placing a stent across the strictured anastomosis with or without balloon dilation using endoscopic procedures can contribute to relief of these complications [5]. To place a stent across the strictured anastomosis, ERCP is the first to be selected, because stent placement under ERCP is feasible if a guidewire could pass the strictured anastomosis. However, identification of the anastomosis is responsible for accomplishment of ERCP, and the possibility depends on the method of reconstruction between pancreatogastrostomy and pancreatojejunostomy. In pancreatogastrostomy, identifying the anastomosis at the lower gastric body is relatively easy using a lateral-viewing endoscope [12]. On the other hand, in many cases with pancreatojejunostomy, the anastomosis is hard to be identified because in general to reach the anastomotic site through the anastomosed jejunum an enteroscope along the route and make a new anastomosis. A high-level technical condition is expected, while in almost all cases of PF the anastomosis occludes, that obstructs a guidewire passing [6,18].

To treat PF, creating a new anastomosis between the pancreatic duct and the digestive tract is necessary. EUS-guided pancreatogastrostomy was reported to treat the complications due to the strictured pancreatojejunostomy [19]. Pancreatogastrostomy is made with stent placement between the pancreatic duct and the gastric cavity. This method is feasible but should be avoided, because various complications have been reported and could be assumed, such as hemorrhage, abscess, pancreatic fistula, gastric perforation, stent migration into the abdominal cavity, and so on [20]. Alternative methods to make a new anastomosis have been reported [6,18]. Introducing EUS endoscope for puncture into the anastomosed jejunum and puncturing the main pancreatic duct through the anastomosed jejunum near the anastomosis to place a stent between the anastomosed jejunum and the main pancreatic duct is the one of them [18]. This method is practical but needs a technical skill to introduce the EUS endoscope for puncture into the anastomosed jejunum giving a careful consideration to perforation. Another method is percutaneous one [6]. This method is to puncture the anastomosed jejunum through the main pancreatic duct percutaneously under abdominal ultrasonography, place a catheter along the route and make a new anastomosis. A high-level technical skill for percutaneous puncture is necessary, and the patient should be thin enough to recognize clearly the anastomosed jejunum and the main pancreatic duct.

Post-pancreatoduodenectomy complications could be treated using interventional endoscopic methods and some percutaneous methods. For treating ARP, endoscopic methods have been established. However, to treat PF needs various devices because of the
occluded anastomosis. Observation with waiting for relief is not just a way for treatment of complications after pancreatoduodenectomy.

REFERENCES