

Development of Pancreatic Duct Stricture in Pancreatitis

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DESCRIPTION

Endoscopic pancreatic duct drainage for chronic pancreatitis

Many patients with chronic pancreatitis develop pancreatic duct stricture, which can cause chronic pain from elevated pressure within the duct as well as recurrent pancreatitis. Stricture may also be the cause of pancreatic calculus or the formation of pseudocysts. Endoscopic pancreatic duct drainage is effective in such symptomatic patients and is indicated, among other things, in the following cases: (i) Patients with a dilated distal pancreatic duct due to stricture and experiencing pain thought to be caused by elevated pressure within the pancreatic duct; (ii) Patients with recurrent obstructive pancreatitis due to stricture; (iii) Patients in whom stricture has resulted in pseudocyst formation causing symptoms; (iv) Pancreatic abscess; and (v) for the prevention of pancreatic calculus. Many subsequent reports described high short-term response rates of 70%-95% but only about 50% long-term recurrence-free rates. All previous randomised controlled trials comparing endoscopic and surgical treatments found to be superior. The pain had completely disappeared 5 years after treatment in 37% of surgical patients but only 14% of endoscopic patients. In addition, patients treated surgically had lower pain scores two years later than those treated endoscopically. Endoscopic treatment is typically considered a first-line treatment because it is less invasive than surgical treatment; however, taking the continuation of this treatment for approximately 1 year as one criterion, surgery must also be considered for patients in whom stent placement is ineffective and those whose abdominal pain recurs after treatment.

Endoscopic drainage of pancreatic fluid collection

Endoscopic drainage is used to drain pancreatic fluid, and depending on the condition, either transpapillary drainage or EUS-guided transgastrointestinal drainage is used. Although transpapillary drainage is a common ERCP-associated procedure, it is not always possible to place the drainage tube within the cyst. The cyst can be approached directly with EUS-guided transgastrointestinal drainage, but because it can only be performed if the cyst is adhering to the gastrointestinal wall, its indications must be carefully considered. Walled-off necrosis (WON) occurs when accumulated exudate or peripancreatic necrotic substances become encapsulated in the bursa omentalis cavity or elsewhere. Because the gastric serosa and the bursa omentalis essentially adhere to one another, puncturing the WON transgastrically under EUS guidance poses little risk of its contents leaking into the abdominal cavity, making it a relatively safe drainage procedure. It is also possible to perform a necrosectomy by creating a large fistula between the stomach and the WON and inserting the endoscope into the cavity of the bursa omentalis. Transpapillary pancreatic duct drainage is indicated by suspected communication between the bursa omentalis cavity and the pancreatic duct.

Because the cyst wall and gastric wall are not normally in contact in Pancreatic Pseudocysts (PPC), when the cyst is punctured, its contents may leak into the abdominal cavity, and EUS-guided transgastrointestinal drainage should be used with caution. Transpapillary drainage is indicated when the PPC communicates with the main pancreatic duct or when the main pancreatic duct narrows on the papillary side of the PPC. In most patients with chronic pancreatitis exacerbations, the gastrointestinal wall and cyst wall adhere to one another, making EUS-guided transgastrointestinal drainage possible.

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