

Surgical Treatment of Pancreatic Duct Stones and Pain

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DESCRIPTION

PD strictures

The 53% of 1071 CP patients had moderate to severe PD lesions, including strictures. A treatment indication is painless uncomplicated CP with an obstructed Main Pancreatic Duct (MPD). Pancreatic Duct (PD) dilatation and stenting can be used to treat dominant PD strictures. New CP diagnoses should be confirmed in patients over the age of 40, as up to 5% of pancreatic cancer patients are initially misdiagnosed as CP and their treatment is delayed. Dilatation with wire-guided balloons of 4-6 mm diameter is usually required prior to plastic stent placement.

In three studies, PD stents were exchanged only on demand, rather than on a regular basis. 66%-73% of those followed for 3.8-14.4 years were pain-free. There were only a few complications associated with stent clogging. An obstructed pancreatic stent can act as a wick, transporting pancreatic juice from the dilated PD to the duodenum *via* the duct and the outer stent wall. However, repeated stent exchanges every 3 months have been suggested to avoid stent clogging. Endoscopic therapy with one 10 Fr stent for an uninterrupted year, with stent exchange combined with control imaging every 6 months, is recommended by ESGE guidelines in painful PD stricture.

PD stones and pain

Endoscopic therapy is particularly effective in patients with a short history of symptoms, stones located in the pancreatic head, no stricture, and PD cleared from the stones. Extracorporeal Shock Wave Lithotripsy (ESWL) can be used for radiopaque

stones larger than 5 mm in diameter because smaller stones are difficult to detect with fluoroscopy. Stones less than 5 mm in diameter are usually removed with ERCP alone. In randomised controlled trials comparing ESWL alone (n=26) to ESWL+ERCP (n=29), both were equally effective in pain relief, but the cost per patient in the ESWL+ERCP group was three times higher. In 38% and 45% of the patients, respectively, the pain returned after 2 years. However, in the presence of downstream stricture, ESWL alone may not be enough to relieve pain in CP. If a stent is placed beyond the stone and stricture, pain can be relieved. We always combine ESWL and ERCP in our unit. Patients with PD stones and pancreatic pseudocysts (n=59) were compared to a control group of 790 patients with PD stones but no pseudocysts in a Chinese study. The majority of patients (98%), had pancreatic sphincterotomy, and 3536 (69%) had a pancreatic stent. 69% of patients with a six-month follow-up were pain-free. Only 5.3% of the time did the intensity of the pain remain constant.

CONCLUSION

Endoscopic therapy is less invasive, but the surgery is permanent. Endoscopic therapy for CP, on the other hand, is time-consuming and may be operator-dependent. Because of the complexities of CP, an early multidisciplinary evaluation and consideration of surgical and non-surgical options is required. Currently, a step-up approach is preferred. Endoscopic therapy is the most effective and safe first-line treatment for CP complications. Invasive CP treatment should be concentrated in high-volume centres. Patients with CP should be encouraged to stop smoking and drinking alcohol. If they do not, we must still care for them and provide some form of treatment.

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