

Importance of Endoscopic Therapy in Chronic Pancreatitis

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DESCRIPTION

Chronic pancreatitis is a long-term illness that requires hospitalisation and readmission. Heavy alcohol consumption and smoking are common causes of this disease. Chronic pancreatitis patients experience acute or chronic pain, recurrent pancreatitis, and complications such as pseudocysts, biliary duct strictures, and pancreatic duct fistulas [1-3]. Strictures and stones in the pancreatic duct can increase intraductal pressure and cause pain. Endoscopic therapy aims to relieve pain and decompress the pancreatic duct, most commonly with pancreatic duct stents and pancreatic duct stone retrieval. Another option for pain relief is early surgery. Furthermore, endotherapy has been shown to be effective in treating complications associated with chronic pancreatitis. In a multidisciplinary meeting, the therapy should be chosen on an individual basis.

Pain in chronic pancreatitis

Patients with Chronic Pancreatitis (CP) can be classified into one of six etiological groups using the TIGAR-O system: Toxic (T), Idiopathic (I), Genetic (G), Autoimmune (A), Recurrent acute and severe pancreatitis (R), and Obstructive cause (O). In Western countries, CP is mostly associated with excessive alcohol consumption (53%-66%) and smoking (53%-75%), and patients may have a combination of risk factors [4-6].

The majority of CP patients experience pain. Patients may experience continuous or intermittent pain, as well as recurrent pancreatitis episodes. Pain in CP is complex and poorly understood. Pancreatic fibrosis and Pancreatic Duct (PD) hypertension are the causes of pain in plumbing problems, and decompressing therapy is usually effective. Peripheral nerve damage in wiring problems causes both stimulus-dependent and spontaneous, neuropathic pain. Endoscopic therapy or surgery are usually ineffective in this situation. Endoscopic therapy should be attempted in a step-up approach if analgesics are insufficient to treat pain, especially if opioids are required [7-9]. Endoscopic therapy aims to reduce increased PD pressure by relieving PD stricture with pneumatic dilatation and PD stent, removing PD stones with Extracorporeal Shockwave Lithotripsy (ESWL), and performing Endoscopic Retrograde

Cholangiopancreatography (ERCP). Endoscopic therapy or surgery should be performed early in the course of the disease to avoid pain centralization and narcotic dependence. Individual treatment options should be considered. Endoscopic therapy is not recommended if there is significant pain but no PD dilatation, stricture, or intraductal stone [10]. If the patient with pancreatic calcification and PD dilatation has no pain, endoscopic interventions are not indicated. When compared to other aetiologies, CP patients with alcoholic aetiology have more complications and hospitalizations. Patients undergoing ERCP or pancreatic surgery have a lower rate of hospital readmission. Patients with CP who are undergoing invasive treatments should be encouraged to quit drinking and smoking.

CONCLUSION

High-quality prospective randomized trials and evidence-based guidelines are required in addition to numerous national and continental guidelines of CP. Then, daily painkiller doses must be carefully monitored, and pain severity scales must be uniform so that the studies are comparable. Endoscopic therapy's role in CP pain must be clarified in comparison to placebo or surgery. 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.

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