

Comment on “Long-Term Outcome of Immediate Versus Postponed Intervention in Patients With Infected Necrotizing Pancreatitis (POINTER)”

Multicenter Randomized Trial

Shuirong Lin, MD,* Ziming Song, MD, PhD,* Xi Yu, MD,* Wenxuan Xie, MD, PhD,* Shunli Shen, MD, PhD,* and Ming Kuang, MD, PhD*

We read with great interest the article recently published in the *Annals of Surgery* entitled “Long-Term Outcome of Immediate Versus Postponed Intervention in Patients With Infected Necrotizing Pancreatitis (POINTER): Multicenter Randomized Trial,”¹ and published in *The New England Journal of Medicine* entitled “Immediate versus Postponed Intervention for Infected Necrotizing Pancreatitis.”² The authors pointed out that postponed drainage with antibiotics in patients with infected necrotizing pancreatitis reduces interventions compared to immediate drainage and offers the opportunity to effectively treat patients with antibiotic therapy alone without increasing the risk of long-term adverse outcomes. However, we have the following concerns about this study.

First, in this study, it was pointed out that catheter drainage was performed on an average of 24 days after the onset of acute pancreatitis symptoms in the immediate drainage group, while catheter drainage was performed on an average of 34 days after the onset of symptoms in the postponed drainage group. At the same time, it was observed that 33 patients (60%) in the immediate drainage group and 21 patients (70%) in the postponed drainage group had largely or fully encapsulated pancreatic and peripancreatic necrosis before drainage. However, the size and distribution of encapsulated effusion have not been detailed in this article, and whether these will affect the timing of drainage interventions.

Second, in the early observation and follow-up, we found that 8 patients (15%) and 10 patients (20%) in the immediate drainage group and the postponed drainage group had bleeding complications, respectively. What was the specific cause of bleeding in these patients? At the same time, we observed that 55 patients (100%) and 30 patients (61%) underwent catheter drainage, and 28 patients (51%) and 11 patients (22%) underwent necrotic tissue excision, respectively, were there

any patients who suffered bleeding after catheter drainage or necrotic tissue excision?

Third, according to the article, 65% and 59% of the patients in the immediate drainage group and the postponed drainage group were affected by gallstones, respectively. Therefore, is surgical treatment for biliary stones targeted in the subsequent treatment of these patients? How long does the surgery take on average? And what percentage of the procedures are laparoscopic?

Fourth, the authors point out that antibiotics are selected according to the results of drainage culture and antibiotic sensitivity. What is the result of bacterial culture of drainage? And what is the main bacterial infection that causes the onset of necrotizing pancreatitis? At the same time, how long is the course of antibiotic application, and what are the specific indications for stopping the drug? As for the postponed catheter drainage group, the authors pointed out that catheter drainage was only performed when the patients in the postponed drainage group were clinically deteriorating or did not improve after antibiotic treatment, so what are the specific criteria?

Fifth, according to the definition of infectious necrosis, 2 of 3 indicators (body temperature >38°C, high C-reactive protein or white blood cell count) were high for 3 consecutive days. How to define the criteria of C-reactive protein and white blood cell count? Because the reference values between different centers may not be consistent.

Sixth, this study is a multi-center study, so how do multiple centers maintain homogeneity? What are the criteria for changing from conservative treatment to drainage in the postponed drainage group? The opinion of the expert group is too general. Is there any specific and detailed reference standard?

Overall, this study suggests that in treating patients with infectious necrotizing pancreatitis, postponed drainage may reduce the number of interventions and provide the opportunity to effectively treat patients with antibiotic therapy alone, without increasing the risk of long-term adverse outcomes. However, the study lacked a clear definition of when to use drainage and how to maintain consistency of care across centers, and the findings of the study could be strengthened if the concerns and issues mentioned above were further clarified and addressed appropriately.

*Center of Hepato-Pancreato-biliary Surgery, The First Affiliated Hospital of Sun Yat-sen University, Guangzhou, Guangdong, People's Republic of China.

Disclosure: The authors declare that they have nothing to disclose.

Reprints: Ming Kuang MD, PhD, Center of Hepato-Pancreato-biliary Surgery, The First Affiliated Hospital of Sun Yat-sen University, Guangzhou, Guangdong, 510080, People's Republic of China. E-mail: kuangmi@mail.sysu.edu.cn

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Annals of Surgery Open (2024) 4:e503

Received: 27 August 2024; Accepted 12 September 2024

Published online 5 November 2024

DOI: 10.1097/AS9.0000000000000503

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