

LETTERS TO THE EDITOR

Dear Editor:

January 20, 1992

We read with interest the paper entitled "Pancreatic Resection Versus Peritoneal Lavage in Acute Necrotizing Pancreatitis" by Dr. Schröder and colleagues in the December 1991 issue of *Annals of Surgery*.

As the authors mention, the greatest difficulty in performing a controlled study on necrotizing pancreatitis is to classify the severity of the disease for randomization. Although the entry criteria in this study (contrast-enhanced CT scan, C-reactive protein) are of prognostic relevance, an important factor for outcome has not been taken into consideration: the rate of primary infection of pancreatic necrosis.

According to Beger et al.¹ and Bradley and Allen,² primary infection of a pancreatic lesion represents an independent prognostic factor predisposing the patient to septic shock and organ failure.

Our results after 37 operations for necrotizing pancreatitis in the last 4 years demonstrated mortality rates of 40% (10/25) in patients with infected necrosis compared with 17% (2/12) in sterile lesions.

The authors give no information on results of bacterial cultures of resected specimen or of peritoneal lavage fluid. We wonder whether the rates of primary infections were equal in both therapy groups; a difference could have influenced the results of this study.

References

1. Beger HG, Bittner R, Block S. Bacterial contamination of pancreatic necrosis: a prospective clinical study. *Gastroenterology* 1986; 91: 433-438.
2. Bradley EL, Allen K. A prospective longitudinal study of observation versus surgical intervention in the management of necrotizing pancreatitis. *Am J Surg* 1991; 161:19-25.

STEPHAN KRIWANEK, M.D.
CHRISTIAN ARMBRUSTER, M.D.
Vienna, Austria

Dear Editor:

February 27, 1992

The letter raises a very important question, and we are well aware of the studies showing the importance of the primary infection of pancreas and the peripancreatic bed in acute pancreatitis. Unfortunately, we have no specimen taken in the current study. In our earlier work with early pancreatic resection, we were unable to culture bacterial growth from the resection specimen, and after this pilot study, we concluded that probably because of the very early surgery in our patients, the cultures were negative. Influenced by these negative culture results, we have not cultured the specimen in the current study. We now have an ongoing study looking into septic problems in acute necrotizing pancreatitis, and these patients all undergo pancreatic

puncture and have bacterial cultures of the sample from the pancreatic bed.

TOM SCHRÖDER, M.D.
Helsinki, Finland

Dear Editor:

January 2, 1991

I read with interest "Sex Differences in Gallstone Pancreatitis" (Taylor TV, Rimmer S, Holt S, et al. *Ann Surg* 1991; 214(6): 667-670). There are three questions I have for the authors.

1. How did the incidence of other risk factors for pancreatitis, specifically, ethanol abuse, compare between men and women?
2. Were patients with symptoms and signs consistent with pancreatitis excluded from that diagnosis if their serum amylase was less than 1000 IU?
3. Symptomatically, what criteria did the authors use to define biliary dyspepsia, biliary colic, and chronic cholecystitis?

JAY S. MARKOWITZ, M.D.
Boston, Massachusetts

Dear Editor:

March 3, 1992

Thank you very much indeed for forwarding the letter that you received from Dr. Markowitz of Boston.

In answer to the questions that are raised, first, we did not look specifically at those with alcoholic pancreatitis, and thus we have no idea about the sex differences here, although of course, alcoholism is much more prevalent in men and therefore one would expect this to be reflected in the incidence of pancreatic disease.

Second, the criteria for inclusion in the studies were a diagnosis of pancreatitis made on the basis of an amylase concentration in excess of 1000 U/L or the presence of acute pancreatitis as diagnosed at laparotomy.

Third, biliary colic was differentiated from biliary dyspepsia by the presence of at least one attack of severe colicky right hypochondrial pain, radiating through to the back and often associated with nausea or frank vomiting. Biliary dyspepsia was regarded as a less severe pain in the same anatomic area, but without the sudden onset and relief characteristic of biliary colic.

Chronic cholecystitis was regarded as a frequent and often continuous discomfort in the right hypochondrium or epigastrium, which had gone on continuously over several months and was exacerbated by the ingestion of fatty foods.

T. V. TAYLOR
Manchester, United Kingdom

Dear Editor:

October 15, 1991

Brennan et al. reported that brachytherapy enhanced the local control of soft-tissue sarcomas, but failed to enhance survival.¹