Letter to the Editor . . .

PANCREATOSTOMY FOR CHRONIC PANCREATITIS WITH CALCULI IN THE DUCT OF WIRSUNG AND DIFFUSE CALCINOSIS OF THE PANCREATIC PARENCHYMA

In March, 1910, while doing an exploratory operation, the above condition was found and relieved by dislocating the pancreas, placing a tube in the duct of Wirsung and establishing permanent drainage, with the tail of the pancreas fixed in the abdominal wall. A description of the operation with illustrations was published in *Annals of Surgery,* Vol. LIII, p. 768, 1911.[1] Sufficient roentgenologic studies of this case had been made to establish a correct diagnosis before operation, except for the fact that the roentgenologist, with the facilities then in use, was not able to show the calculi which filled the pancreas.

This is written to call attention again to the importance of this means of restoring patients who are suffering with this condition, to a comfortable state of health, and to report the results in a patient who lived for 32 years after operation.

In March, 1925, I received a letter from Sir Berkeley Moynihan, asking for "the latest report of your case of caudal pancreatostomy," saying he wished to mention the case in the new edition of his book on abdominal operations. Following is my reply to Sir Berkeley Moynihan's letter, which is a fair sample of the entire 30 years of the patient's health, with her pancreatic fistula.

Sir Berkeley Moynihan
Leeds, England
Dear Sir Berkeley Moynihan,

I saw the patient about whom you have inquired three months ago; in a letter just received, her condition remains the same.

She is occupied in a clerical position in the local post office. She still keeps her fistula open, wearing a small rubber tube which she removes and inserts herself.

The drainage is collected in a rubber condom and leakage around the tube is negligible. There is no excoriation of the skin about the fistula, nor has there ever been any.

At rare intervals she has some colic similar to that described in the original report, but of a lesser degree, and never requiring medical relief. This is always due to cessation of drainage and is followed by relief occasioned by the working out of small calculi and their discharge through the fistula.

The total amount of drainage is inconsiderable, and less than it was soon after operation.

Diabetic symptoms have never appeared.

Sincerely yours,

This patient who enjoyed a useful and comfortable life for more than 30 years with her pancreatostomy, died December, 1942. Learning that Dr. Irvin Abell of Louisville, Kentucky, was in attendance at her last illness and had done an operation on her, I wrote to him for information which he graciously sent me in the following letter:

Louisville, Ky:
January 7, 1943.

Dear Doctor Link:

Replying to your letter, I am pleased to answer your questions regarding M. M.

1. Patient was still wearing the tube connected with the tail of the pancreas and a small amount of drainage was collected each day.
2. She had no glycosuria while under my care.
3. The condition for which I operated was a right subphrenic abscess due to abscess of the liver; autopsy showed multiple abscesses of the liver. There was no discoverable causative lesion; the fact that the abscesses were multiple would lead one to infer that the infection entered through the portal system.

She had endometrial cysts in her pelvis and a mild cholecystitis without stones.

4. There was, insofar as I was able to determine, no relation between the condition of her pancreas and the liver abscesses.

5. At autopsy, what had been the tail and body of the pancreas had become practically a fibrous cord, all pancreatic tissue having disappeared except a small amount at the head of the pancreas. The pathologist who made the post-mortem expressed surprise that the small amount of pancreatic tissue present had been sufficient for the needs of her body.

Very sincerely yours,

Irvin Abell.

The frontiers of surgery have been pushed back since this operation was done in 1910 and reports of operations for calcareous pancreatitis are not unusual. Pancreatectomy[2, 3] seems to be the operation of choice, although Waugh, Walters, Gray, and Priestly recently stated: "Our experience in the past with total pancreatectomy has been uniformly disappointing for diffuse chronic pancreatitis with calcification and intolerable pain."[4]

Caudal pancreatostomy, instead of pancreatectomy, should be used for calcareous pancreatitis, because it is a simple, easy procedure which should have a low mortality; the function of the pancreas is preserved and there is no subsequent morbidity (diabetes) or mortality due to loss of the pancreas. The use of splanchnicectomy[5] to interrupt the sensibility of the severe pains due to obstruction and distention of the duct of Wirsung can hardly vie with pancreatostomy, which relieves the colic of distention by permanently doing away with its mechanism, *vis-a-tergo*. Section of the sphincter of Oddi as done by Doubilet and Mulholland,[6] has given good immediate results, but the future conditions that may develop in such a section are not as amenable to control as is the pancreatostomy opening which can be kept patent.

That a patient may live comfortably in normal activity for more than 30 years with a calcareous pancreatitis by the aid of caudal pancreatostomy is here shown.

Goethe Link, M.D.
Indianapolis, Indiana.

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