

IMPACT OF ENDOSCOPIC PANCREATOGRAPHY ON THE MANAGEMENT OF RELAPSING PANCREATITIS

P B Cotton MD MRCP and T R Heap MRACP

Department of Gastroenterology, The Middlesex Hospital, London

Sixty-three patients (48 men, 15 women) who had suffered 2 or more attacks of acute pancreatitis were referred for endoscopic retrograde cholangiopancreatography (ERCP). Pancreatograms were obtained from 56. A normal duct system was seen in 20 patients and only minor duct calibre variations in a further 8. Major duct abnormalities were demonstrated in 28 cases: these were generalized in 6 (marked dilatation with or without multiple strictures) and localized in 22 (main duct obstruction 5, stenosis 11, and cysts 6). Coincident retrograde cholangiography revealed gallstones in 6 patients in whom previous biliary radiology had given negative results. ERCP provoked 3 minor episodes of pancreatitis and infection of 2 cysts. Both cysts required drainage and 1 patient died at 6 weeks, after leaving hospital.

We have suggested previously¹ that endoscopic pancreatography provides useful information concerning surgical management of patients with recurrent pancreatitis, and we have followed up these patients (after periods of 6 months to 3 years) in an attempt to assess the role of pancreatography and the results of surgery.

When gallstones were found appropriate surgery was performed, and all patients were either greatly improved or symptom-free as a result. Of the remaining patients with no main pancreatic duct obstruction, half were symptom-free at follow-up and the remainder were considerably improved. None had deteriorated. Thus the endoscopic demonstration of a normal or nearly normal pancreatogram is a useful guide to prognosis and strongly suggests that local pancreatic surgery should not be considered.

In contrast, patients with a major duct ob-

struction had a poor prognosis. Seven patients underwent cyst drainage; of these, 2 were rendered symptom-free, 3 were improved, and 2 had deteriorated. Perhaps the most interesting group were 4 patients with duct obstruction or major stenosis in the mid-pancreatic body, with relatively normal duct appearances distal to this in the head. Left hemipancreatectomy appeared logical, but the results were disappointing (3 patients unchanged and 1 worse). Three of these patients had alcohol-induced pancreatitis, but 2 of them were thought to have stopped drinking. Despite this, further attacks had occurred.

Larger series and much longer follow-up are clearly required for exact clarification of the role of pancreatography in patients with recurrent pancreatitis, but certain preliminary conclusions can be drawn. ERCP is useful in such patients for the following purposes: (1) exclusion of gastric, duodenal, and papillary disease; (2) accurate assessment of pancreatic and sphincter function by analysis of pure pancreatic juice and papillary manometry; (3) detection of previously overlooked gallstones; (4) prevention of exploratory surgery when pancreatography shows no major duct obstruction; and (5) detection of major duct obstructive lesions.

In view of the hazard of introducing infection into cysts, ultrasonography (by the new grey-scale technique) should precede pancreatography. If pancreatography shows a cyst surgical drainage should be seriously considered within 24 h. The results of surgery 'tailored' to the duct abnormalities have so far been disappointing.

¹ Cotton, P B, and Beales, J S M (1974) *British Medical Journal*, 1, 608.