

Surgical Management of Pancreatic Pseudocysts

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KEYWORDS

• Pancreatic pseudocysts • Cystogastrostomy • Laparoscopy • Pancreatitis

KEY POINTS

- Open surgical intervention for pancreatic pseudocysts has a high success rate but significant morbidity.
- Laparoscopic surgical techniques for pancreatic pseudocysts are safe and feasible with possible improvements in complications and length of stay.
- Surgical treatment of pseudocysts in the setting of chronic pancreatitis should treat the underlying parenchymal and ductal disease.
- Multidisciplinary team effort is necessary for the successful treatment of pancreatic pseudocysts.

Pancreatic pseudocysts (PPs) develop in 40% of patients with chronic pancreatitis and 15% of patients with acute pancreatitis.¹ These pseudocysts are persistent peripancreatic fluid collections with a well-defined wall. Indications for intervention include infection, rupture, bleeding, or obstruction of adjacent structures, which can lead to symptoms, such as bloating, nausea and vomiting, abdominal pain, and jaundice. Open surgical intervention was previously the gold standard for treatment of PP with its inherent risk of morbidity and mortality. The advent of minimally invasive techniques, however, has led to an increase in available treatment options.

The treatment approach to PP should be individualized and take multiple factors into consideration. These multiple factors include underlying acute versus chronic pancreatitis; the development of symptoms caused by the PP or complications, such as venous thrombosis or biliary obstruction, the location of the pseudocyst, and single versus multiple PPs and the status of the pancreatic duct.²⁻⁴ Surgical management of uncomplicated PPs in the setting of acute pancreatitis, PPs and chronic pancreatitis, and complicated PPs are discussed separately.

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UNCOMPLICATED PANCREATIC PSEUDOCYSTS AFTER ACUTE PANCREATITIS

Uncomplicated PPs that develop after an episode of acute pancreatitis are persistent, simple fluid collections with no necrosis or debris that have a mature wall and can become symptomatic. A majority of published studies include this group of patients with uncomplicated retrogastric PPs. These patients usually have otherwise normal pancreatic parenchyma and normal pancreatic ducts. In 2002, Nealon and Walsler² correlated the success of PP drainage with pancreatic ductal anatomy and emphasized the importance of the pancreatic ductal anatomy in determining appropriate treatment of PP. Patients with uncomplicated PP are candidates for successful internal drainage procedures as treatment of their symptomatic PP. Correspondingly, PPs in the head, uncinate process, neck, and body of the pancreas may also be amenable to transpapillary endoscopic drainage if there is communication between the PP and the pancreatic duct. PPs located in the tail of the pancreas or in areas distant from the pancreas do not usually respond to transpapillary endoscopic drainage and, therefore, should be considered for internal drainage or resection.

Once a decision has been made to perform internal drainage for the treatment of a PP, the next branch point in the decision tree is whether to approach the drainage with surgery or endoscopy. A majority of PPs are located posterior to the stomach and abuts the stomach or duodenum, making them amenable to both surgical and endoscopic intervention (**Fig. 1**). The traditional open surgical approach is performed via a midline or bilateral subcostal incision with wide exposure of the stomach and duodenum. In the 1970s and 1980s, success rates were high but postoperative morbidity after surgical intervention for PPs was 30%.⁵ In the hopes of decreasing operative morbidity and mortality associated with an open approach, the first descriptions of laparoscopic internal drainage of PPs were reported in 1994.⁶ Multiple publications since that time have demonstrated the efficacy and feasibility of the laparoscopic approach.⁷⁻¹⁰ Typically, patients are placed in the supine position and 3 port sites are used. The surgeon may be on the right side of the patient or between the patient's legs. The camera port is placed in the supraumbilical midline with 2 working ports in the left and right midclavicular lines. On entering the abdomen, the retrogastric PP

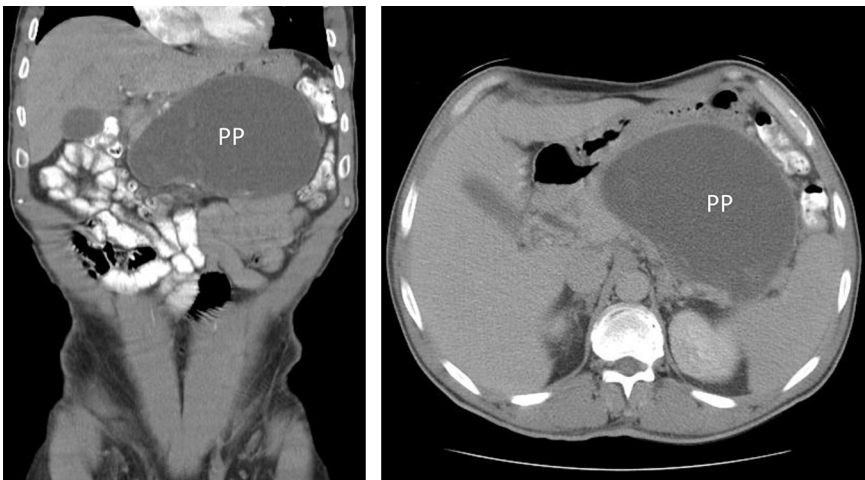


Fig. 1. CT images demonstrating uncomplicated retrogastric pancreatic pseudocyst, amenable to surgical or endoscopic intervention.

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