Complete Summary

GUIDELINE TITLE

Operative treatment for chronic pancreatitis.

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract (SSAT). Operative treatment for chronic pancreatitis. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2004. 3 p.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates the previously issued version: Society for Surgery of the Alimentary Tract. Operative treatment for chronic pancreatitis. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Chronic pancreatitis

GUIDELINE CATEGORY

Diagnosis
Evaluation
Treatment

CLINICAL SPECIALTY

Family Practice
Gastroenterology
Internal Medicine
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs

TARGET POPULATION

Adult patients with chronic pancreatitis

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis/Evaluation for Surgery

1. Assessment of symptoms
2. Computed tomography (CT) scan
3. Magnetic resonance cholangiopancreatography (MRCP)
4. Endoscopic retrograde cholangiopancreatography (ERCP)
5. Measurement of CA-19-9 levels
6. Angiography of the celiac and superior mesenteric arteries
7. Baseline evaluation of pancreatic exocrine and endocrine function
8. Baseline evaluation of nutritional status, pain severity, use of pain medication/narcotics, employment status, and quality of life

Operative Treatment for Chronic Pancreatitis

1. Pseudocyst decompression, ductal decompression (Puestow pancreaticojejunostomy procedure), or resection
2. Biliary-enteric decompression
3. Partial pancreatic resection (such as distal pancreatectomy, pancreaticoduodenectomy, or duodenal preserving pancreatic head resection/decompression [i.e. Beger or Frey procedures])

Note: The following alternative treatment procedures are also considered: endoscopic sphincterotomy and short-term stent placement.

MAJOR OUTCOMES CONSIDERED

- Pain relief
- Postoperative diabetes and steatorrhea (fatty stool)
- Body weight
- Length of hospital stay
- Risks and complications associated with surgery

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Symptoms and Diagnosis

Pain is the major disabling symptom in patients with chronic pancreatitis, often leading to associated weight loss and/or narcotic dependency. Diabetes, jaundice, and problems with digestion are also frequently seen.

Computed tomography (CT) scan, ultrasonography, magnetic resonance cholangiopancreatography (MRCP), or endoscopic retrograde cholangiopancreatography (ERCP) usually makes the diagnosis of chronic pancreatitis and its complications. Typical findings can include a dilated pancreatic duct or strictures with dilatations of the duct ("chain of lakes"), pancreatic calcification, or pseudocyst. Biliary or duodenal obstruction and evidence of portal hypertension may also be present. It is difficult to distinguish between chronic pancreatitis and pancreatic cancer, especially in patients without pancreatic calcification. Marked elevation of serum CA 19-9 in a patient without jaundice is highly suggestive of pancreatic cancer.

By clearly defining pancreatic and biliary ductal anatomy, ERCP and MRCP can help to select patients who might benefit from surgery and to plan the most appropriate operation. In patients with atypical gastrointestinal bleeding and pancreatitis, angiography of the celiac and superior mesenteric arteries can detect and embolize a pseudoaneurysm. It is also important to establish a baseline of pancreatic exocrine and endocrine function, nutritional status, pain severity, use

of pain medication or narcotics, employment status, and quality of life. Continued ingestion of alcohol or narcotics should be addressed in either a medical or surgical management plan.

Treatment

Patients with disabling abdominal pain, evidence of chronic pancreatitis, and pancreatic ductal dilatation are best managed by pseudocyst decompression or ductal decompression (Puestow pancreaticojejunostomy procedure), while patients without ductal dilatation are best treated with resection. Biliary-enteric decompression may also be required in patients with chronic pancreatitis and bile duct obstruction. Although preservation of pancreatic tissue is desired to maintain both exocrine and endocrine function, partial pancreatic resection (such as distal pancreatectomy, pancreaticoduodenectomy, or duodenal preserving pancreatic head resection/decompression [i.e. Beger or Frey procedures]) is at times the preferred treatment. While alternative procedures such as endoscopic sphincterotomy, short-term stent placement in the major pancreatic duct, or pancreatic pseudocyst may provide short-term relief of symptoms, long-term results are as yet unknown.

Qualifications for Performing Day Surgery

At a minimum, surgeons who are certified or eligible for certification by the American Board of Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent should perform operations for pancreatitis. These surgeons have successfully completed at least 5 years of surgical training after medical school graduation and are qualified to perform operations on the pancreas. Pancreatic surgery should preferably be performed by surgeons with special knowledge, training, and experience in the management of pancreatic disease. The level of training in advanced laparoscopic techniques necessary to conduct minimally invasive surgery of the pancreas is important to assess. The qualifications of a surgeon performing any operative procedure should be based on training (education), experience, and outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Initial pain relief following operative treatment for chronic pancreatitis can be expected in 75 to 80% of patients and sustained in selected patients for 3 to 5 years. Successful relief of pain after operation is associated with weight gain in most patients.

Subgroups Most Likely to Benefit

Overall, the best outcomes occur in patients who are compliant with pancreatic enzyme replacement and abstain from alcohol and narcotics use.

POTENTIAL HARMS

Risks and complications associated with operation for chronic pancreatitis, with a frequency in the range of 0.5 to 5%, include:

- Infection
- Bleeding
- Biliary and pancreatic anastomotic leaks
- Aggravation of existing acute pancreatitis

The mortality rate of pancreatic surgery is currently below 5% for major resections and less for non-resective decompressive operations.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines have been written by the Patient Care Committee of the Society for Surgery of the Alimentary Tract (SSAT). Their goal is to guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the **range** of acceptable clinical practice and should not be construed as a standard of care. These Guidelines require periodic revision to ensure that clinicians utilize procedures appropriately, but the reader must realize that clinical judgment may justify a course of action outside of the recommendations contained herein.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Society for Surgery of the Alimentary Tract (SSAT). Operative treatment for chronic pancreatitis. Manchester (MA): Society for Surgery of the Alimentary Tract (SSAT); 2004. 3 p.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2004 May 15)

GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

GUIDELINE COMMITTEE

Patient Care Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

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This guideline updates the previously issued version: Society for Surgery of the Alimentary Tract. Operative treatment for chronic pancreatitis. Manchester (MA): Society for Surgery of the Alimentary Tract; 2000. 3 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Society for Surgery of the Alimentary Tract, Inc. Web site.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-U, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-0461.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on March 28, 2000. The information was verified by the guideline developer as of May 30, 2000. This guideline was updated by ECRI on September 8, 2004.

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