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STRATEGY OF DIAGNOSIS, PROGNOSIS AND MANAGEMENT OF ACUTE DESTRUCTIVE PANCREATITIS

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Prognosis and management of severe acute pancreatis are closely connected initial clinical and biochemical data, which necessitates to work out a strategy of accurate assessment and treatment at the very beginning. For the time period 1978-1990 in our Clinic 422 patients with acute pancreatitis were treated. Of them 71 (21,1%) were with destructive necrotic pancreatitis. Males - 47, females - 24, mean age - 56,4. With biliary cause were 21 pts, alcoholic and alimentary - 32, postoperative - 6, and unsettled - 12. Pathological findings in the operated patients were: with pancreatic necrosis - 64, peripancreatic necrosis - 18 and retroperitoneal necrosis - 15, without infection - 30 and with infection - 31. In 10 pts pancreatic abscesses were found. Prognostic analysis was made according to Ranson's scale (11 criteria). With 3 and less criteria were 48%, 4 to 6 criteria - 34% and 7 and more - 18%. The characteristics of peritoneal effusions found in laparoscopy and abdominocentesis is of great significance for accurate diagnosis and prognosis. We have performed abdominocentesis in 19 pts and laparoscopy (both in conjunction with drainage-lavage) in 28 pts. In 17 pts the peritoneal effusions were muddy, in 16 - hemorrhagics and in 14 - rusty. US also is of great significance for exact diagnosis. CT imaging accurately demonstrates necrotic changes and their evolution in the pancreas. Sixty-four of all 71 patients were operated. In 46 operation was performed up to the 8th day from admission of the patients and in 18 - after this period. Reoperations (2-3 and more) for treatment of pancreatic and peripancreatic abscesses were performed in 16 pts. The following operations were done:

1) Closed drainage (double and triple) of lesser sack - 29 pts; 2) Cholecystectomy, choledochotomy, T-tube drainage and lesser sack drainage - 12 pts; 3) Pancreatonecrectomy and lesser sack drainage - 12 pts; 4) Pancreatonecrectomy and COLD (laparostomy, open drainage) - 11 pts. Postoperative mortality - 43,6% (28 pts). Most common postoperative complications were: pancreatic fistulae - 3, hemorrhage - 4, pseudocysts - 7, abscesses - 2, thoracic complications - 8, etc. Strategy of diagnosis, prognosis and treatment of acute necrotic pancreatitis is closely connected and depends on the severity of initial changes, i.e. from the very beginning it is quite clear about the course

and outcome of the process - as some authors say, according to the law "All or nothing". For accurate assessment of the evolution and prognosis of the acute pancreatitis we should base on: 1) clinical signs, 2) clinical and biochemical criteria (Ranson's), 3) data from laparoscopy, abdominocentesis, ultrasongraphy and CT. Abdominocentesis and laparoscopy are quite important when applied in our Clinic since 1978, both combined with drainage-lavage. The presence of muddy, hemorrhagic and rusty effusions, with high level of pancreatic ferments is evidence for severe pancreatitis with poor prognosis. Laparoscopic drainage-lavage via 2-3 tubes with antibiotics and antiferments decreases peritoneal irrigation and the level of ferments, reduces intoxication and renal failure. It gives a chance to avoid early, ill-judged laparotomy.

According to majority of authors, operation should be done, if possible, after 8th day. Early operation is unconsiderable and even harmful. Indications for early operation for us were: peritonitis, hemoperitoneum and biliary cause of pancreatitis. In cases of early operations we have done lesser sack drainage, cholecystectomy and T-tube drainage (biliary cause). Biliary pancreatitis can be defered by performing endoscopic sphincterotomy. In general, biliary pancreatitis has more favourable prognosis (postoperative mortality in our patients - 21 - was 28,5%). Operation after 8th day can be radical because there is demarcation of necrotic areas and we can perform pancreatonecrectomy. There are still controversies about the way of drainage and repeated operations - COLD or closed drainage. We must emphasize that despite our clear idea to restrain from early operation in most of our pts we have operated earlier than 8th day, mainly because of worsening of patients. 35% of all deceased patients died up to 8th day. The mere facts suggest the need of individual judgement of every single patient. According to our experience, the results of managements of destructive pancreatitis are still unsatisfactory despite introduction of modern therapeutic and operative methods. Nevertheless, we are deeply convinced that conservative methods of treatment should be performed to the highest degree in order to bring out the patient to the second week when we can and must perform radical operations and reoperations with mandatory pancreatonecrectomy and wide drainage allowing repeated control.