Classical duct-to-mucosa pancreaticojejunostomy

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Management of the remnant pancreas during pancreaticodudenectomy is the very important process, because pancreatic leakage followed by arterial psedoaneurysm rupture is the most serious complication associated with operative mortality. To prevent the pancreatic leakage, various surgical technique as well as pharmacologic prophylactic treatment has been developed including various types of occlusion of main duct or pancreaticoenterostomy. Among various type of pancreaticoenterostomy, I'll show you classical end-to-side duct-to-mucosa pancreaticojejunostomy in my presectation.

For my technique, I prefer 2 layer sutures for duct-to-mucosa pancreaticojejunostomy. For outer layer suture, I used to use interrupt black silk suture, but I changed my policy using continuous prolene suture, since prof SW Kim has published an article on better result with continuous suture for pancreaticojejunostomy in 2007. For inner layer suture, I use 5-0 Vicryl and make 4 or 7 stitch according to the diameter of main pancreatic duct.

When we evaluated our technique using ISGPS classification, ISGPF Grade A fistula occurred in 31.7 % of the patients, but we could not detect any differences between fistula free group and grade A group in terms of clinical course including postoperative hospital days. Therefore, I think that grade A fistula is not a fistula in a genuine meaning. Grade B and Grade C fistula rates were 2.8% and 7.8%, respectively. Delayed JP removal, nutritional support and antibiotics were required more frequently in grade B and C group. Remnant pancreatic texture was the most significant predictive factor for pancreatic leakage and decreasing tendency was shown in pancreas cancer group.