

EDITORIAL

NONOPERATIVE MANAGEMENT OF INFECTED PANCREATIC NECROSIS

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Many years ago, we published the first report in the literature of a patient having infected pancreatic necrosis who survived following strictly medical therapy, namely antibiotics.¹ That paper was harshly criticized, perhaps rightly so, since conventional wisdom recommended—and to some extent still advises—open necrosectomy and drainage for nearly 100% of such patients.²

It should however be noted that, in that case, administering only antibiotics was neither a simple option, nor an unauthorized experiment, for the very good reason that the patient himself irrevocably refused any surgical intervention on religious grounds.

Even at that time, experienced surgeons in international congresses would privately concede that every once in a while they had come across this situation: nonoperated patients who had survived on antibiotics only, but publication of such results was generally regarded as an anathema.

Fifteen years and several articles later, infected pancreatic necrosis has not become a trivial disease – and probably never will – nor has conservative therapy become mainstream.

However, advances in interventional radiology and other forms of minimally invasive management have greatly benefited patients with deep-seated infected foci in general, including those associated with severe pancreatitis.^{3,4}

Of course, minimally invasive management is not the gold standard for infected pancreatic necrosis, and open surgical debridement of contaminated foci still produces the most reliable results, with present reported mortalities of 20% to 25%.^{2,5} However, the use of minimally invasive therapies is growing in certain institutions and could still become a generally accepted alternative.

Disseminated infected necrosis and poorly localized bacterial foci do not lend themselves to easy and effective percutaneous management, so nonclassical treatment should be reserved for centers with interest and expertise in this area.

Mortality with laparoscopy or percutaneous drainage^{3,4} tends to exceed that of the best surgical centers.^{2,5} Still, as techniques improve and favorable outcomes become more frequent, it is conceivable that in the future these nonclassical techniques could become the therapies of choice.

Exclusive antibiotic therapy, as recently discussed by Amico et al,⁶ has been advocated by some, but it is unlikely to become a first-line option unless new drugs or prescription protocols that are particularly effective for such complex and dangerous intraperitoneal and retroperitoneal infected lesions are developed. Patients in good clinical condition tend to have the best results, according to preliminary findings as well as to our own experience;¹ however, these are also the subjects with favorable outcomes in face of any therapeutic modality.

Interventional radiology is already advised for metabolically and hemodynamically unstable subjects or others who are somehow unfit for surgery.^{4,5} As already mentioned, this may soon become an uncontroversial area as more compelling evidence supports revision of therapeutic guidelines.

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