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Outcomes of early reoperation in severe pancreatic fistula and/or haemorrhage after pancreaticoduodenectomy

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Introduction: Although advances in multidisciplinary management reduce the mortality after pancreaticoduodenectomy (PD) from medical complications, postoperative pancreatic fistula (POPF) and/or postpancreatectomy haemorrhage (PPH) still remain as common morbidities and main causes of mortality. The morbidity of POPF and/or PPH after PD in our centre, Yangon Specialty Hospital, is 18–30% per year. And there are still ongoing disputes regarding management of POPF and/or PPH after PD.

Methods: It is a hospital based prospective descriptive study carried out between 2018 January and 2020 April in surgical units at Yangon General Hospital, New Yangon General Hospital and our centre. Total 28 reoperated patients with POPF and/or PPH patients after PD were included in the study. The indications for reoperation in this study were patients with SIRS together with drain amount more than 300 ml/day and/or blood in drain/ NGT with Hb drop ≥ 3 g% or sentinel bleed. Preoperative CECT scan was done if condition was favorable. In this study, demographic distribution, proportion of reoperation, timing of reoperation, types of procedure were also recorded while outcomes of reoperation was emphasized in this eposter.

Results: There were 56 patients who suffered from POPF and/or PPH after PD for periampullary carcinoma during this study period. Although reoperation was advised to 34 patients, who met the indications for reoperation, six of them declined operation for various reasons. Therefore, total 28 patients were reoperated (50%). Fig. 1 showed the intraoperative findings of POPF and PPH patient. Median timing of reoperation was 9 days (2–25 days) and 71% were reoperated within 10 days. While external tube wirsungosotmy (Fig. 2) was performed in majority of POPF cases as a damage control surgery, PPH patients ended up with mainly laparotomy and GDA ligation for arrest of haemorrhage because of lack of interventional radiology (IR) support at present.

Fig. 1. Showing intraoperative findings of POPF and PPH.

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Fig. 2. Showing method of external tube Wirsungostomy insertion.

Among reoperated patients, 14 patients (50%) survived and 14 patients (50%) expired. Therefore, overall in-hospital mortality was 50% in reoperated cases. The main cause was multi-organ failure due to severe sepsis.

According to the Fig. 3, in-hospital mortality rate of POPF was 16% and that of PPH was 66% while that of POPF and PPH was 80% in this study.

Fig. 3. Outcomes of reoperative management.

Gangl et al. (2011) [1] reported that the combination of pancreatic fistula and severe hemorrhage was a strong predictor of postoperative mortality (relative risk (RR), 22.75). And Tamijmarane et al. (2006) [2] pointed out that patients themselves are in such a moribund condition that their associated mortality rate ranges between 38 and 50%.

In addition, it was surprisingly found that all six patients, who needed reoperation, died with conservative management in this study.

Conclusions: It is found that reoperation is necessary in patients when it is indicated i.e. mainly clinical based. Early reoperation and damage control surgery is found to have better outcomes in especially POPF patients before organ failure or haemorrhage supervenes. And it is hard to say the accurate timing of reoperation and optimal procedures because this study has some limitations like small sample size, and limited resources for multidisciplinary management. Therefore, further study with larger sample size and optimal resources and management will be necessary for better and more significant results.

References

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