Longitudinal Pancreatico-Jejunostomy Vs lateral Pancreatico-Gastrostomy as a Drainage Procedure for Pain Relieve in Chronic Pancreatitis Done in a Tertiary Referral Centre of Eastern India

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Dear Sir,

IJS is improving in quality leaps and bounds. For which, we wait for the next issue. While going through the last issue, we found an article titled ‘Longitudinal pancreatico-jejunosotomy vs lateral pancreatico-gastrostomy as a drainage procedure for pain relief in chronic pancreatitis’ [1]. As we also do lot of pancreatic work, we started reading with interest.

In the first line on the introduction of the topic, ‘chronic pancreatitis (CP)’ is defined as a ‘procedure’ possibly an avoidable typographical error. The whole of introduction with various statements is without a single reference and not seen in any publication.

We thought the study design is good in this comparative study. But the method of randomization is missing. The authors have mentioned that the study tools were questioners for grading pain. It was fine but needed little further clarification on the methods of grading pain and time frame of the questioners. As CP cannot be confirmed from symptomatology alone, some form of cross-sectional imaging is essential not only for the confirmation of diagnosis but also for the planning of surgery and deal with the associated complication. The investigation asked for are estimation of lipase, amylase, liver function test, 24-h faecal fat estimation and imaging studies like USG abdomen, CECT, ERCP and MRCP.

Have the authors done all these tests in all cases? How they selected the patients based on all the tests needed clarification. Doing all the tests is not without economic burden in a country like India.

They have operated cases with hyper-amylasemia (17.1 and 14.3 % respectively). We felt this would have been difficult surgery; however, this indicated good surgical handiwork with some pancreatic fistula. Similarly, alkaline phosphatase is also raised in 22.9 and 20 % in group A and B, but there is no mention of dealing the biliary obstruction and the result thereafter in this study.

Biliary stones causing CP is controversial and rarely seen [2]. The authors have described one fifth of cases in both the groups and not explained at all. What was the basis of diagnosing CP in such cases? The association of gallstones in CP need not be the cause. They have not mentioned any inflammatory mass which is common and Frey’s procedure recommended excision of inflammatory mass for better pain relief. The author has stated that gastric juice neutralizes the trypsin effect and stones get dissolved in gastric juice, which again is authors own view without any reference. The physiological fact is the pancreatic enzymes do not get activated in acidic pH and not neutralized. Regarding the resolution of leftover pancreatic stones, two points given below may be appropriate.

1. At surgery, all stones are supposed to be removed.
2. Stones are formed by precipitation of *pancreatic stone protein* first and later calcium salt. Proteins get further precipitated in the presence of acid [3], so complete dissolution is possibly unpredictable. If the author had left some stones and it has dissolved, they must say so with proof.

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Lastly, references 10 and 15 are the same and possibly were overlooked.

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