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EDITORIAL

Editorial

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Diagnosis and surgical resection of the pancreas have remained a challenge over the decades. But with advances, the scenario has improved a lot. Still, many issues are unresolved. With technical success and improved patient care, the surgical mortality has decreased significantly, in some series to less than 1% [1]. However, this has not translated to patient success, since the overall cancer survival remains low. This remains a challenge [2]. Further advances include laparoscopic and robotic techniques [3, 4]. One such technique of pancreatico-gastrostomy is described in this issue. These have not been adopted widely and are yet to be the standard of care. Issues that need to be addressed include safety, both surgical and oncologic outcomes, cost and training, and if possible, the learning curve.

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Another area of advancement in surgery is vascular resection and reconstruction. Neoadjuvant therapies have increased the prospects of vascular resection in borderline operable cases. More research is also needed to identify the vascular invasion pre- or intra-operatively. Earlier, the resections were limited to portal vein or the superior mesenteric vein; however, it has now been extended to the superior mesenteric artery, coeliac axis, and common hepatic artery with varying results [2]. More prospective data on morbidity, mortality, and oncologic outcomes are required before categorical recommendations.

Post-operative pancreatic fistulas pose quite a problem; however, their nomenclature for reporting has been standardized [5, 6]. The overall morbidity after pancreatic surgery hovers around 30–60% and is a matter of concern [7]. This issue has a review of exocrine function of pancreas post-pancreaticoduodenectomy. In addition, one article addresses the predictive factors for re-surgery. There is a demonstrated volume-outcome relationship in pancreatic surgeries and notably, Europe and the USA have moved in this direction of "centralization" [8]. The health policymakers of the country need to look into areas where centralization of therapy would benefit the patient in terms of costs and outcomes.

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