



Comments on “Central pancreatectomy for benign or low-grade malignant pancreatic lesions - A single-center retrospective analysis of 116 cases”



Dear editor,

We read with great interest the article by Paiella S et al. [1]. This retrospective study evaluated the incidence of postoperative complications in patients with central pancreatectomy (CP) of a large sample size and identified that CP is a suitable surgical method for benign or low-grade malignant tumors of the neck of the pancreas, and compared with pancreaticoduodenectomy (PD) or distal pancreatectomy (DP), it can preserve the pancreatic function and reduce the incidence of postoperative diabetes. Herein, we would like to raise the following comments:

In this study, the author reported on high rate of postpancreatectomy hemorrhage (PPH) (7.8%) in CP. We estimated that the high rate of PPH may be relatively low coagulation environment in the gastric cavity after pancreogastric (PG) anastomosis. Author also state that PG was associated with higher rates of postoperative pancreatic fistula (POPF) than pancreojejunal (PJ) anastomosis (80% vs 48.4%, $p = 0.004$). This is the opposite of Topal B et al. reports (8% vs 19.8%, $P = 0.002$) after PD for pancreatic or periampullary tumors in a multicentre randomised trial [2]. We think that it may be due to the small sample size of PG and PJ, or difference between CP and PD. We look forward to the further study of PG and PJ in CP.

Furthermore, they stated that the placement of a stenting within the main pancreatic duct were done at each surgeon's discretion and also the placement of a stent within the main pancreatic duct was not associated with nor prevented the development of any postoperative complications. However, Zhang L et al. reported in their study that early pancreatic duct obstruction is associated with postoperative pancreatic long-term complications (occurred in 23% patients) as postoperative exocrine insufficiency, new onset diabetes and recurrent pancreatitis. Sustained internal and pancreatic stent may improve pancreatic duct obstruction [3]. Nevertheless, here confusing us is that no patient developed complications in above study. In our opinion, it may be necessary to routinely perform pancreatic stent to prevent the occurrence of

postoperative pancreatic duct obstruction.

Overall, we deeply appreciate the authors' work and agree with Paiella S et al. that CP might be indicated for selected benign or low-malignancy pancreatic tumors. It may be necessary to routinely perform pancreatic stent to prevent postoperative pancreatic duct obstruction. PG and PJ remain controversial historically. We may need a large randomised controlled trial to compare PG and PJ in CP.

Disclosures

Drs. Bingqing Du and Xubao Liu have no conflicts of interest or financial ties to disclose.

References

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