to accurately interpret imaging for hernias in all the imaging, with 79% overall accuracy).

The conclusion of our manuscript is that physicians should be critical of the radiologic reports issued for inguinodynia or chronic pelvic pain, given the high false negative rate of pelvic CT (73%) and MR imaging (43%) reports in detecting inguinal hernias. Accurate interpretation of imaging in these patients may help reduce delay in diagnosis and help expand the population of patients who would benefit from surgical repair.

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Disclosure Information: Nothing to disclose.
Disclosures outside the scope of this work: Dr Towfigh was a paid consultant to TELA Bio and received grant payments from BARD and Intuitive Surgical.

Acute Care Emergency General Surgery Model: Assigning Priority

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I read with great interest the article entitled, "Acute care surgery model and outcomes in emergency general surgery" in the *Journal of the American College of Surgeons*, by To and colleagues.[1] This is the first multi-institutional study that showed significant reduction (31%) of 30-day mortality in emergency general surgery (EGS) cases in an acute care surgery (ACS) model compared with that of the general surgery service (GSS) model. It delivered an important message worldwide, where EGS is being delivered in the GSS model by surgeons with subspecialty interests or with suboptimal training in EGS.

Patients requiring EGS are unwell, often old and frail, with major other health problems that significantly increase the risk of postoperative complications and death. Providing unrestricted access and high-quality EGS service remains a global challenge, particularly in low- and middle-income countries (LMIC) of the world. In a prospective, multicenter cohort study, which collected data on 10,745 patients from 357 centers in 58 countries, who underwent emergency abdominal surgery, the 24-hour (high 1.1%, middle 1.9%, low 3.4%; $p < 0.001$) and 30-day (high 4.5%, middle 6.0%, low 8.6%; $p < 0.001$) mortality were 3 times higher in LMIC compared with mortality in high-income countries.[2]

In England, more than half of approximately 600,000 EGS patients admitted present with acute abdomen. In 2014, The Royal College of Surgeons of England, in association with other royal medical colleges, published a report giving 13 recommendations to make the emergency service sustainable and resilient.[3] Similar recommendations were also made by the National Institute for Health Research and National Clinical Advisory Team for reconfiguration of the acute surgical services in the UK, which focused on safety, work force, and cost as the 3 key drivers for the success of EGS provision. Delivery of 24-hour service led by a senior decision-maker (consultant) and supported by relevant specialists and facilities was emphasized, and this has been implemented and evaluated continuously. To improve the EGS service in the UK, initiatives such National Emergency Laparotomy Audit (NELA) and Enhanced Peri-Operative Care for High-risk Patients (EPOCH) trial are underway.[3,4]

There are handful of substantive consultant posts in EGS in the UK National Health Service. It is believed that patients and funders could benefit from a new specialty of EGS, in which unscheduled emergency admissions are managed by a dedicated consultant-led team. The options of models include consultant of the week, consultant with interest in EGS, and consultant in EGS.[5]

It is commendable that the US currently has 20 approved acute care surgery training fellowship programs and has demonstrated leadership in advancing EGS through the ACS model. This study, despite several limitations, has delivered an important message to the surgical fraternity to move forward and assign priority to embrace the ACS model in the best interest of EGS patients. Motivating surgeons, who are the pillars of the ACS model, to pursue career in EGS remains a major challenge worldwide, and it should be addressed by developing appropriate infrastructure, training schemes, and an environment that would allow optimum work-life balance, and quality assurance.[6]

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Disclosure Information: Nothing to disclose.

Pasireotide for the Prevention of Postoperative Pancreatic Fistula: A Debate Not To Close Too Early

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We read with great interest the article written by Kunstman and colleagues entitled, "Outcomes after pancreatectomy with routine pasireotide usage."[1] The authors presented a single-center, prospective, nonrandomized study with the primary aim of assessing the incidence of clinically relevant postoperative pancreatic fistula (CR-POPF) and abscess formation in patients undergoing pancreatic resection since the initiation of routine perioperative pasireotide administration.[1] Their study compared a pasireotide group of 652 patients to the placebo group of the original randomized trial, previously published by the same authors.[1,2] They concluded that pasireotide allowed a marked reduction in the rate of clinically significant abscesses and POPF (a statistically significant absolute risk reduction of 7.6%, from 20.9% in the placebo group to 13.3% in pasireotide group), confirming the effect observed in the randomized trial of 2014.[1,2]

In 2014, Allen and colleagues[2] thrilled the scientific community with their randomized, double-blind, placebo-controlled trial that demonstrated the ability of pasireotide to significantly reduce the CR-POPF rate (a statistically significant absolute risk reduction of 12%, from 21% in the placebo group to 9% in pasireotide group). We all thought we finally got a solution to the heavy problem of pancreatic fistula after pancreatic resection. This understandable enthusiasm had quickly directed the attention of some authors on cost-effectiveness analysis, "almost forgetting" the evaluation of the real effectiveness of the drug.[3]

However, in a short time, the results obtained by studies published later, with the aim of analyzing the effect of pasireotide on the prevention of POPF, discouraged the scientific community.[3-6] In particular, the single-center, prospective, nonrandomized studies published by Dominguez-Rosado and colleagues,[4] Elliott and associates,[5] and Young and coauthors[6] were relevant. By comparing the pasireotide group (of 127, 111, and 116 patients, respectively) with historical control groups, similar results emerged: there were no statistically significant differences in terms of CR-POPF rate, CR-POPF rate in different cohorts of patients (pancreaticoduodenectomies, distal pancreatectomies, and pancreaticoduodenectomies with high fistula risk score), length of hospitalization, postoperative complication, readmission, and mortality rate.[4-6]

Therefore, publication of the study by Kunstman and colleagues,[1] albeit with the limitations of a nonrandomized study but with a far broader pasireotide group than in previous nonrandomized studies, "has rekindled the community's hope."

Therefore, we emphasize how important it is not to quickly set aside pasireotide and its potential benefits, which must be studied extensively through multicentric, nonsponsored, randomized, controlled trials using the International Study Group for Pancreatic Fistula (ISGPF) grading system for the assessment of CR-POPF severity.

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Disclosure Information: Nothing to disclose.