SESAP Critique
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ITEM 270

This 27-year-old sustained blunt abdominal trauma and a pancreatic injury leading to a pancreatic-cutaneous fistula. Percutaneous drainage of pancreatic fluid collections has been described. Patients with nonalcoholic and nonbiliary associated pancreatitis are candidates for percutaneous drainage of fluid collections. Subsequent monitoring of the drain site for persistent drainage is required and development of a pancreatic-cutaneous fistula is a recognized complication of this procedure. Initially these patients should be treated conservatively. Total parenteral nutrition (TPN) may be indicated for patients who do not tolerate dietary intake and octreotide should be administered. If the drainage remains significant, many such patients with isolated major pancreatic duct injuries require reoperation. Persistent drainage should prompt further studies to show whether there is discontinuity of laceration of the pancreatic duct. Computed tomographic (CT) scan and the contrast studies (fistulogram) demonstrate that this injury is in the head of the gland. The duct remains open, and a proximal stricture will probably prevent the fistula from closing. Distal pancreatectomy is inappropriate because of the proximal location of the injury. A Roux-en-Y jejunal loop to cover the fistulous tract is the best alternative in this situation.

Continued observation and antibiotic therapy are not warranted at this point, and gastrojejunostomy would fail to deal with the pathologic anatomy. Although low-dose radiation therapy may abolish exocrine function, it would produce pancreatic insufficiency and would not be the treatment of choice. ERCP would probably have a lower success rate than a Roux-en-Y loop in controlling the fistula.

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