SHORT COMMUNICATION

Severe Acute Pancreatitis: Have We Defined the Role of Palliative Care?

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ABSTRACT

In the last many years, necrosectomy that was done with wrong indications or at the wrong time has harmed more patients than it could benefit. It is the persistence and perseverance of bold pancreatic surgeons who continued the brave struggle in spite of poor results, which has made it possible today that we can treat the majority of Severe Acute Pancreatitis (SAP) patients with acceptable morbidity and mortality. As this evolution of surgery for SAP continues and pancreatic surgeons debate to reach consensus, subgroups of patients who have highest mortality are emerging. This is the time to start selecting patients who really benefit from the aggressive surgical treatment and sparing a small subgroup of the patients who will have worse results irrespective of the best possible treatment from unnecessary intervention. Considering palliative care in these patients to avoid futile interventions looks like a reasonable approach and needs further study.

INTRODUCTION

Aggressive necrosectomy as the standard of care remained unquestioned for patients with Severe Acute Pancreatitis (SAP) for many years. In the early 1990s, it was realized that this approach will not help most patients with sterile pancreatic necrosis [1,2]. However, patients with infected pancreatic necrosis (IPN) were subjected to aggressive surgical intervention because of the "surgical dogma" of delay in surgery resulted in extremely high mortality. It was proved subsequently that early surgery in IPN results in unacceptably high morbidity and mortality [3]. Till today surgical management of severe acute pancreatitis continues to evolve. Pancreatic surgeons and pancreatologists have yet to define the indications, appropriate timing and method of necrosectomy. In last many years it has become clear that the necrosectomy which was done with wrong indications or at the wrong time has harmed more patients than it has benefited. The persistence and perseverance of bold pancreatic surgeons who continued their brave struggle inspite of poor results has made it possible today that the majority of SAP patients can be treated with acceptable morbidity and mortality rates. Prediction of mortality in SAP patients has also been a subject of intensive research. Scores, such as the Acute Physiology and Chronic Health Evaluation (APACHE II) [4] & Sequential Organ Failure Assessment (SOFA) [5], have been widely used for these patients. Despite the validation of these prospective scoring systems, determining with certainty which specific patients will live or die remains challenging.

As this evolution of surgery for SAP continues and pancreatic surgeons debate to reach a consensus, subgroups of patients who have the highest mortality rates are emerging. Many patients present in the early phase of SAP with multiorgan dysfunction syndrome (MODS) without any drainable collection. They may deteriorate despite best supportive care. Some of them may develop collections subsequently, but do not respond to percutaneous drainage and force the surgeon to perform necrosectomy. Patients on "Step up approach" who fail on all possible minimally invasive approaches are finally considered for necrosectomy as a last resort with a poor outcome [6]. Few patients who develop late-onset organ failure may be too sick to undergo any further intervention. Significant numbers of patients ends up in major complications after necrosectomy and undergo multiple reoperations. Some of them may be already in MODS, and any attempts to do a reoperation may be futile. Others who need repeated surgeries may end up having a difficult Enterocutaneous fistula or Intraoperative/ postoperative hemorrhage. Studies have also described the factors associated with high mortality in patients in SAP like extremes of age, significant co morbidity, multiorgan failure at surgery, and a High APACHE II score on admission or before surgery [7,8]. We need to recognize the limits of care to avoid excessive and futile intervention for these patients.

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The term 'palliative care' outside the domain of oncology is interesting but not unheard of. Though palliative care is routinely integrated into critically ill patients, its role in these patients of SAP who are at high risk of mortality has not been described previously [9]. Surgeons always think of management with curative intent, especially in non-malignant diseases. It's hard for pancreatic surgeons to stop ongoing treatment and even harder for the patient or relatives to decide the goal of care; giving insight into when to stop treating is a must to relieve the suffering in patient with a poor surgical outcome. Many a time no one knows exactly when to stop and the treatment continues as per physician philosophy and patients or relatives wishes.

Though all present studies focus on how to win the battle against the Pancreatitis, let us also define the subgroup of SAP patients in whom the surgeon cannot win over the disease. Current research should focus on improving the prognosis in this subgroup. Till then pancreatic surgeons also need to think about relieving suffering in these patients. Involving palliative care into surgical decision making to avoid futile interventions represents an important step toward improving surgical care for SAP patient's limited prognosis.

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CONFLICT OF INTEREST

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