

RAPID COMMUNICATION

Influence of Tumor Size on the Complexity of Laparoscopic Left Lateral Sectionectomies

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ABSTRACT

The Whipple surgery (Pancreaticoduodenectomy) involves the removal of the pancreas head, the first section of the small intestine (duodenum), the gallbladder, and the bile duct. Following surgery, the remaining organs are reattached to allow you to digest food normally. The most common operation for treating pancreatic cancer is pancreaticoduodenectomy, often known as the Whipple procedure. The treatment is named for Allen Old father Whipple, former chairman of the Department of Surgery at Columbia University and the method's inventor.

INTRODUCTION

Acute and chronic pancreatitis is common pancreas illnesses that, despite being benign, are associated with a high risk of malnutrition and may require nutritional support. Acute necrotizing pancreatitis affects 20% of patients with acute pancreatitis, is linked to higher morbidity and mortality, and may necessitate enteral or parenteral feeding, as well as further endoscopic, radiological, or surgical procedures. Chronic pancreatitis is a condition in which the pancreatic gland is inflamed and fibrosis develops. Exocrine and endocrine dysfunction, as well as abdominal pain resulting in decreased oral intake, is common consequences of the condition. All of the aforementioned are risk factors for malnutrition. As a result, people with chronic pancreatitis should be regarded as high-risk, and they should be screened and supplemented accordingly. Furthermore, in patients with chronic pancreatitis, osteoporosis and an increased risk of fractures should be recognized, and preventive interventions should be taken [1].

Diagnostic imaging is used in patients with acute pancreatitis (AP) for a variety of reasons, including aetiology detection, diagnosis of pancreatitis in an uncertain clinical situation, assessment of the severity of the disease,

and evaluation of its consequences. Despite the potential benefits of these imaging investigations in the setting of AP, diagnostic imaging has a number of negative implications, including an increase in the effective radiation dosage received by patients with AP and increased health-care expenses, which often go unnoticed by management. The increased incidence of acute pancreatitis in the Western world is putting a financial strain on the country, with annual health-care costs of more than 2.5 billion dollars [2].

Despite national evidence-based recommendations for the use of diagnostic imaging in patients with AP, inappropriate a often, particularly in the early hospital course. The goal of this article is to review the imaging guidelines for acute pancreatitis in terms of when to image and when not to image, with the goal of reducing unnecessary imaging [2].

A rise in acute pancreatitis has been recorded over the world. Acute pancreatitis continues to be associated with high morbidity and death despite advancements in access to care, imaging, and interventional procedures. Despite the existence of clinical practice guidelines for the care of acute pancreatitis, recent audits of the condition's clinical management have revealed significant noncompliance with evidence-based recommendations. This emphasises the significance of developing recommendations for the diagnosis and treatment of acute pancreatitis that are both intelligible and implementable. The goal of this guideline is to give evidence-based guidelines for the treatment of mild and severe acute pancreatitis, as well as acute pancreatitis complications and gallstone-induced pancreatitis [3].

Acute pancreatitis is a prevalent condition that necessitates multimodal treatment. The new Atlanta classification, published in 2012, defines the terminology

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needed to debate the morphological and clinical varieties of acute pancreatitis among doctors from various backgrounds. The role of radiologists is mostly dependent on Computed Tomography (CT), which allows radiologists to characterize the morphology of this disease and forecast clinical severity using imaging severity indicators. Furthermore, CT or ultrasound-guided drainage, in combination with endoscopy, is the current treatment of choice for collections that arise as a consequence. The purpose of this work is to communicate the concepts introduced in the updated Atlanta classification and to describe radiologists' current involvement in the diagnosis and treatment of acute pancreatitis. [4].

The Atlanta categorization of acute pancreatitis allowed for standardized study reporting and improved physician communication. A change is required due to deficiencies discovered and a better understanding of the condition. This multinational, web-based consensus establishes precise categories for classifying acute pancreatitis based on clinical and radiologic criteria that are easily detected. The fact that pancreatologists worked together to reach this agreement should boost widespread adoption [5].

CONCLUSION

Patient survival after resection is mostly dictated by tumour biology, including characteristics such as tumour diameter, lymph node status, resection margin

status, and DNA content, and is unaffected by pylorus-preserving pancreaticoduodenectomy. A PPPD showed more efficacious than the Whipple surgery in patients with pancreatic head cancer but no direct invasion of the duodenum or pyloric ring and no perigastric lymph node metastases. Furthermore, while the prognosis was improved following curative resection, an extended lymphadenectomy in combination with the PPPD was deemed required to assure cancer-free status following resection.

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