

# Letter to the editor

## Treatment and outcome in acute pancreatitis

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Dear Editor:

After reading the article written by H. Puerto et al. and published by your magazine, I considered it important to comment. The article is about treatment and outcomes of patients with acute pancreatitis over three years at a university hospital.

I would like to mention that the American Gastroenterology Association recommends starting enteral nutrition early rather than late on the bases of 11 randomized controlled trials. Those trials did not demonstrate decreasing mortality but did demonstrate fewer infectious complications including peripancreatic necrosis, multiple organ failure and surgery to address pancreatic necrosis. (1, 2) The recommended route is oral (with either gastric or post-pyloric catheter) depending on the tolerance of each patient. Similarly, all possible clinical mechanisms for the use of this route such as antiemetics, prokinetic agents, pancreatic enzymes, soluble fiber and antidiarrheal agents should be exhausted if need be. (3)

In severe cases of acute pancreatitis, enteral nutrition may need to be delayed until the patient is stabilized, but it is still the preferred method of feeding. (4) This is so because parenteral nutrition has higher rates of organ failure, infectious and metabolic complications and mortality than does enteral nutrition. (5, 6) The time needed to achieve daily energy and protein requirements can precipitate the use of complementary parenteral nutrition or even total parenteral nutrition in patients without previous malnutrition for whom the daily enteral nutrition volume cannot be increased. According to the 2012 Atlanta classification of acute pancreatitis, neither organ failure, localized complications nor systemic complications should occur after the first 48 hours of mild acute pancreatitis. Thus, most of these patients will tolerate the oral route, and very few will require gastric or post-pyloric feeding tubes. Moderately severe acute pancreatitis leads to reversible organ failure, systemic complications or local complications. Some of these may require parenteral nutrition. Severe acute pancreatitis may require parenteral nutrition more frequently.

Due to the high risk of adverse outcomes, surgery is only recommended when there are infectious complications refractory to intensive antimicrobial treatment, progressive clinical deterioration, severe mechanical complications such as behavioral syndrome refractory to clinical management, obstruction, bleeding or perforation. (4, 7) If surgery is necessary, it should be carried out as late as possible, to allow the necrosis and inflammation of the peripancreatic tissues to be defined as well as possible.

## Conflicts of interests

The author has no conflicts of interest.

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# Response to the letter to the editor

## Treatment and outcome in acute pancreatitis

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Mr. Editor:

After carefully reading Dr. Abel Salvador Arroyo-Sánchez's letter responding to "Outcomes of Three Years of Experience Managing Acute Pancreatitis at a Fourth Level Hospital in Huila, Colombia", we would like to make a few comments. (1)

First, we want to thank Dr. Arroyo for his interest in contributing to our knowledge of treatment of this disease. We agree with his assessment of the nutritional schemes recommended for acute pancreatitis by most evidence-based guidelines. (2-4) These guidelines clearly establish the benefits of enteral nutrition in patients with acute pancreatitis. As shown in Table 12, more than 80% of patients in our work received enteral or mixed nutrition. In the specific case of patients with necrosis, 62% received this type of nutrition. (1) It should be noted that the enteral route had been exhausted in patients who received parenteral nutrition.

As can be seen in Figure 2, a high percentage of patients with pancreatic necrosis in our study (62.5%) underwent surgery. These patients had complications refractory to conservative medical treatment or were not candidates for percutaneous or endoscopic management. As shown in Table 13, there were fatal outcomes in three of these cases. All of these patients had Marshall severity scores upon admission that were over four while their average APACHE II score was 16 points. From the outset, their prognoses had shadows cast over them.

Finally, we consider that all contributions of letters to the editor show interest in the article and enrich research.

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