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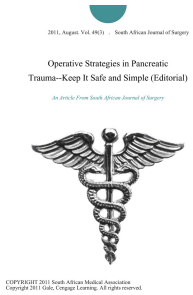
OPERATIVE STRATEGIES IN PANCREATIC TRAUMA KEEP IT SAFE AND SIMPLE EDITORIAL EBOOKS 2019



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Injuries to the pancreas are infrequently encountered in surgical practice but may result in substantial morbidity and mortality if pancreatic, visceral vascular and adjacent organ injuries occur in combination. (1-4) Recent data indicate a rising incidence of pancreatic trauma owing to high-speed car accidents and an escalation in civil violence involving increasingly dangerous weapons. (1-4) In South African and North American cities, penetrating abdominal injuries from gunshot wounds are the most common cause of pancreatic trauma, while in Western Europe, England and Australia, traffic accidents predominate. (4-7) The mechanism of injury dictates intervention. After penetrating injuries, the diagnosis is usually established at laparotomy, while in those who have sustained blunt polytrauma, pancreatic injuries are generally detected by radiological investigations, allowing some patients to be managed without recourse to surgery. This geographical variation in aetiology and the difference in investigative approach results in considerable disparity in the reported severity and spectrum of pancreatic injuries. (1,4,5) The unique anatomic features of the pancreas influence the site and type of injury while the proximity of major vascular structures and surrounding viscera compounds the complexity of injury management. Severe blunt and penetrating abdominal trauma invariably damages adjacent organs, including liver, spleen, duodenum and colon. Isolated pancreatic injuries, though rare, pose specific problems in diagnosis and management owing to the lack of overt clinical signs. Ultimately, the outcome of a pancreatic injury is influenced by the cause and complexity of the specific injury, the amount of blood lost, duration of shock, speed and adequacy of resuscitation, number of associated injuries, and the quality and magnitude of surgical intervention. (8-10) The unforgiving nature of complex pancreatic injuries results in substantial mortality rates, and most patients who die from a pancreatic injury do so within the first 48 hours of injury owing to uncontrolled bleeding from associated vascular or major adjacent organ injuries. (1-4) Late mortality is generally the result of persistent intra-abdominal infection or multiple organ failure. Neglect of a main pancreatic duct injury invariably leads to major complications that include pseudocysts, fistulae, sepsis and secondary haemorrhage. (4,5,10-13)

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