Pancréatite chronique: prise en charge

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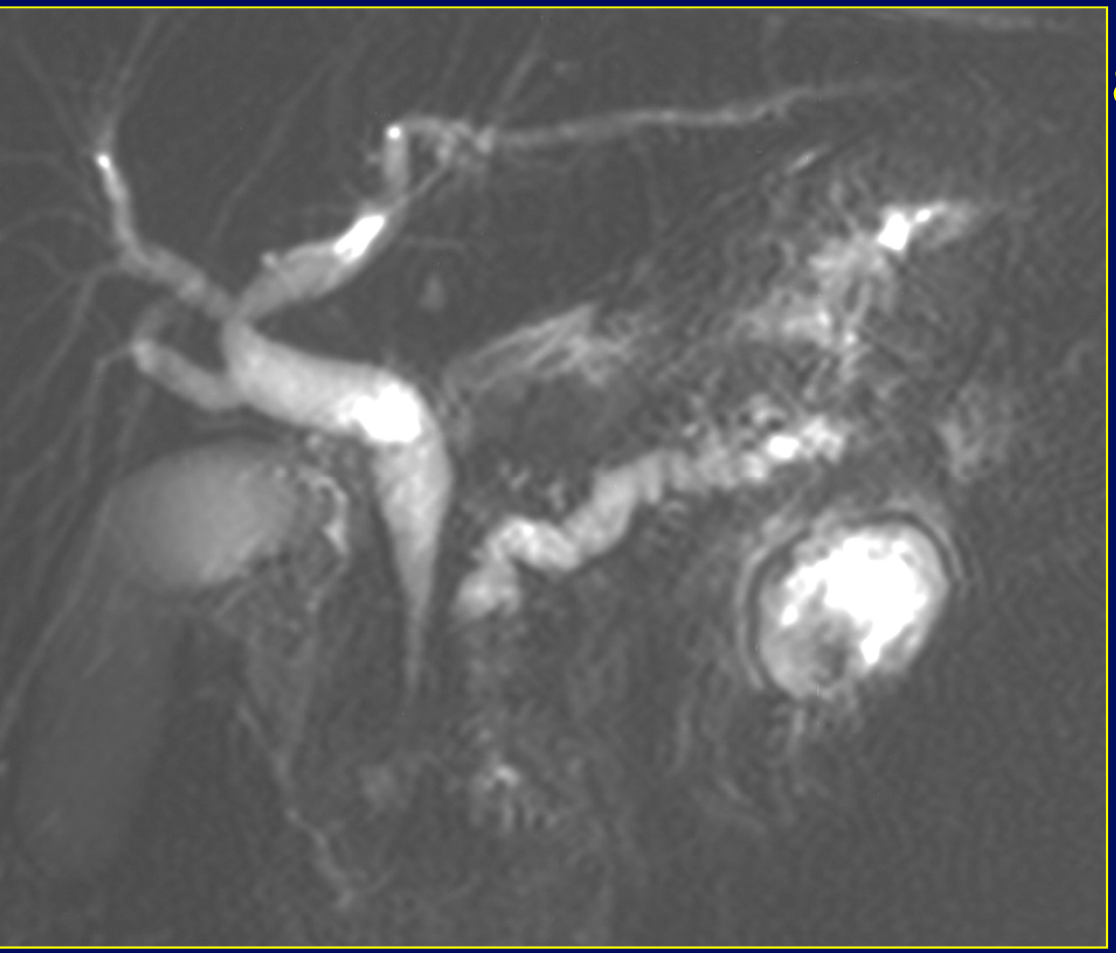
Pancréatite chronique
Définition



PANCREATITE CHRONIQUE

Epidémiologie et étiologie

Prise en charge thérapeutique

Pancréatite chronique: toujours l'alcool ?

Rôle de l'alcool

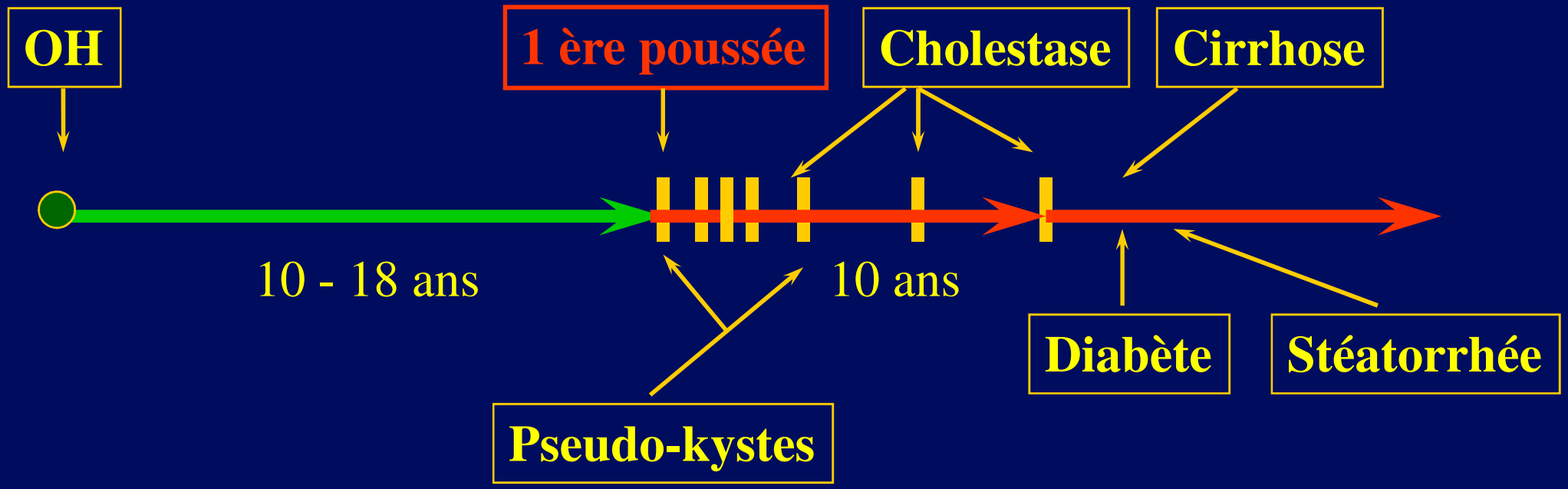
- 60-80% des cas de PC sont liés à l'alcool
- 5-10 % des patients OH développent une PC

D'autres facteurs sont donc impliqués

Pancréatite chronique alcoolique

- **Symptômes**
  - **Douleurs**
  - **Diarrhées (IPE)**
  - **Amaigrissement (IPE)**
  - **Diabète**

Pancréatite chronique: histoire naturelle



CLASSIFICATION CAUSALE

TIGAR-0 classification

1. **T**oxic-metabolic
   - **alcohol**, **tobacco**
   - hypercalcemia
2. **I**diopathic
3. **G**enetic
   - trypsinogen mutation
   - CFTR mutations, SPINK-1
   - deficiency in alpha-1-antitrypsin
4. **A**uto-immune
   - Sjögren, biliary cirrhosis
   - IBD
5. **R**ecurrent acute pancreatitis
6. **O**bstructive
   - post-pancreatitis, obstruction of PD
   - pancreas divisum

Gastroenterology 2001

Rôle du tabac

- Cesser le tabac améliore l'évolution de la PC

- Le tabac est associé à un risque de PA et PC

PANCREATITE CHRONIQUE

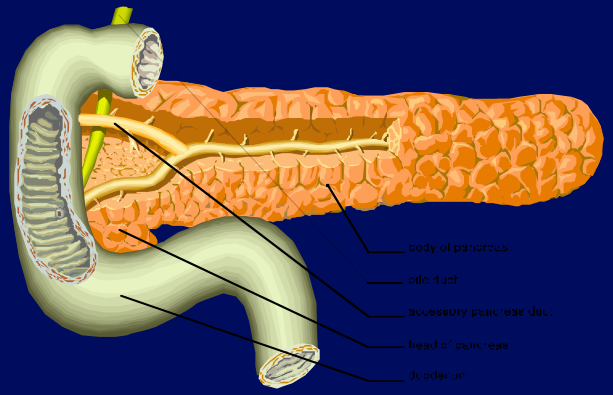
Epidémiologie et étiologie

Prise en charge thérapeutique

insuffisance exocrine

Maldigestion pancréatique

Enzyme outpout



Maldigestion

Stéatorrhée → Malnutrition

Fermentation colique

Flatulences

Prolifération bactérienne

Elastase fécale

Dominguez Munoz et al. Scand J Gastro 1995

Très bonne stabilité du test

95% des contrôles: 175-2500 µug/g

Sensibilité: 100% pour pancréatite chronique calcifiante

0% pour les lésions canalaires minimes

Endpoints du succès thérapeutique

- Diminution stéatorrhée
- Prise pondérale ou stabilisation pondérale
- Diminution des diarrhées

- Graisses < 60 gr/j
- Pullulation bactérienne ?
- IPP ?

PANCREATITE CHRONIQUE

Epidémiologie et étiologie

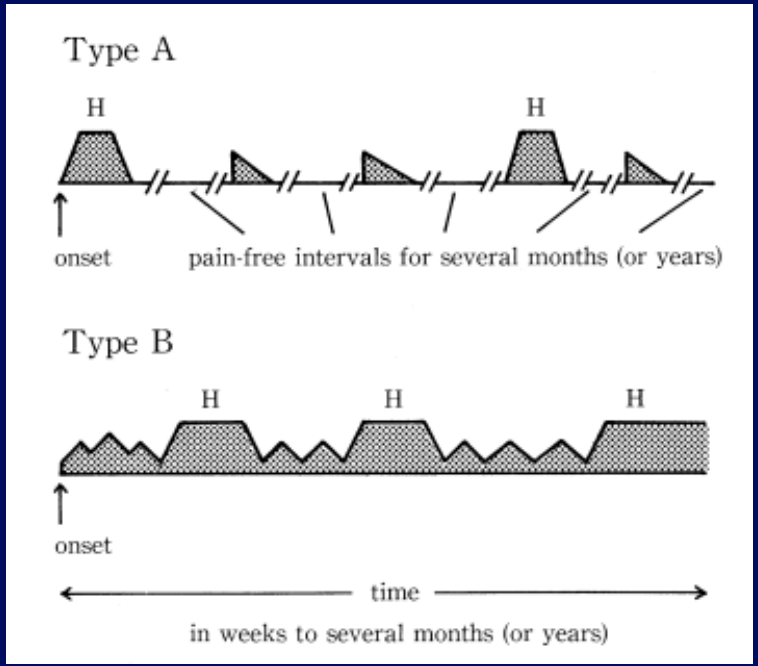
Prise en charge thérapeutique

douleurs

Douleurs

- **Douleurs abdominales** 85%
- 2 grands types:
  - **type A intermittentes**
    - Intervalles libres plusieurs mois
    - Douleurs 2 à >10 jours, très intenses

    → **hospitalisation du patient.**
  - **type B**
    - Douleurs prolongées quotidiennes et/ou régulièrement ≥ 2 mois



- NB **15% patients avec PC sans douleur**

Ammann R. Internal Medicine 2001

TRAITEMENT DE LA DOULEUR

ARRET TABAC et ALCOOL ?

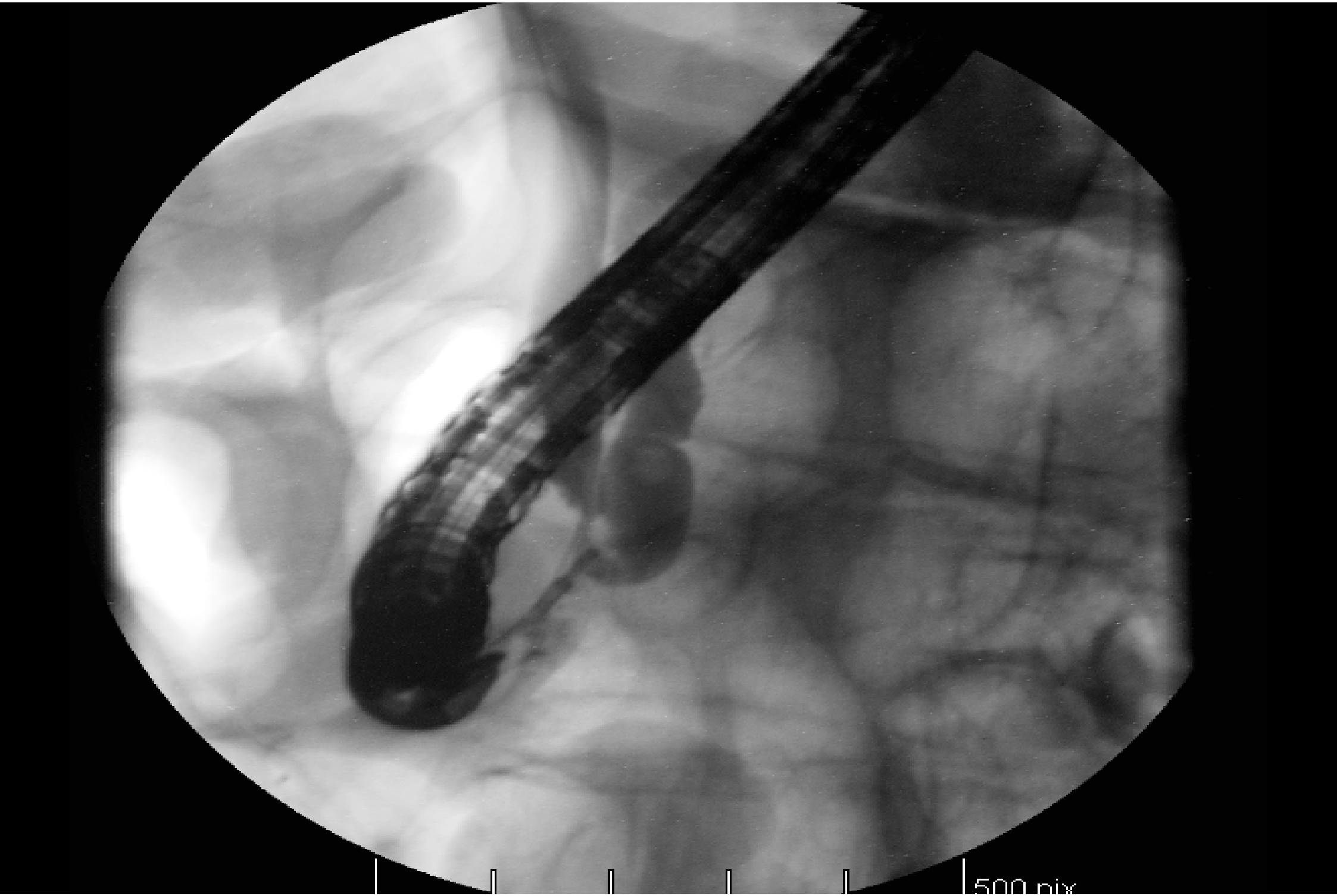
LE TEMPS

ANALGESIQUES

BLOC NEURAL

ENZYMES PANCREATIQUES ?

ENDOSCOPIE/CHIRURGIE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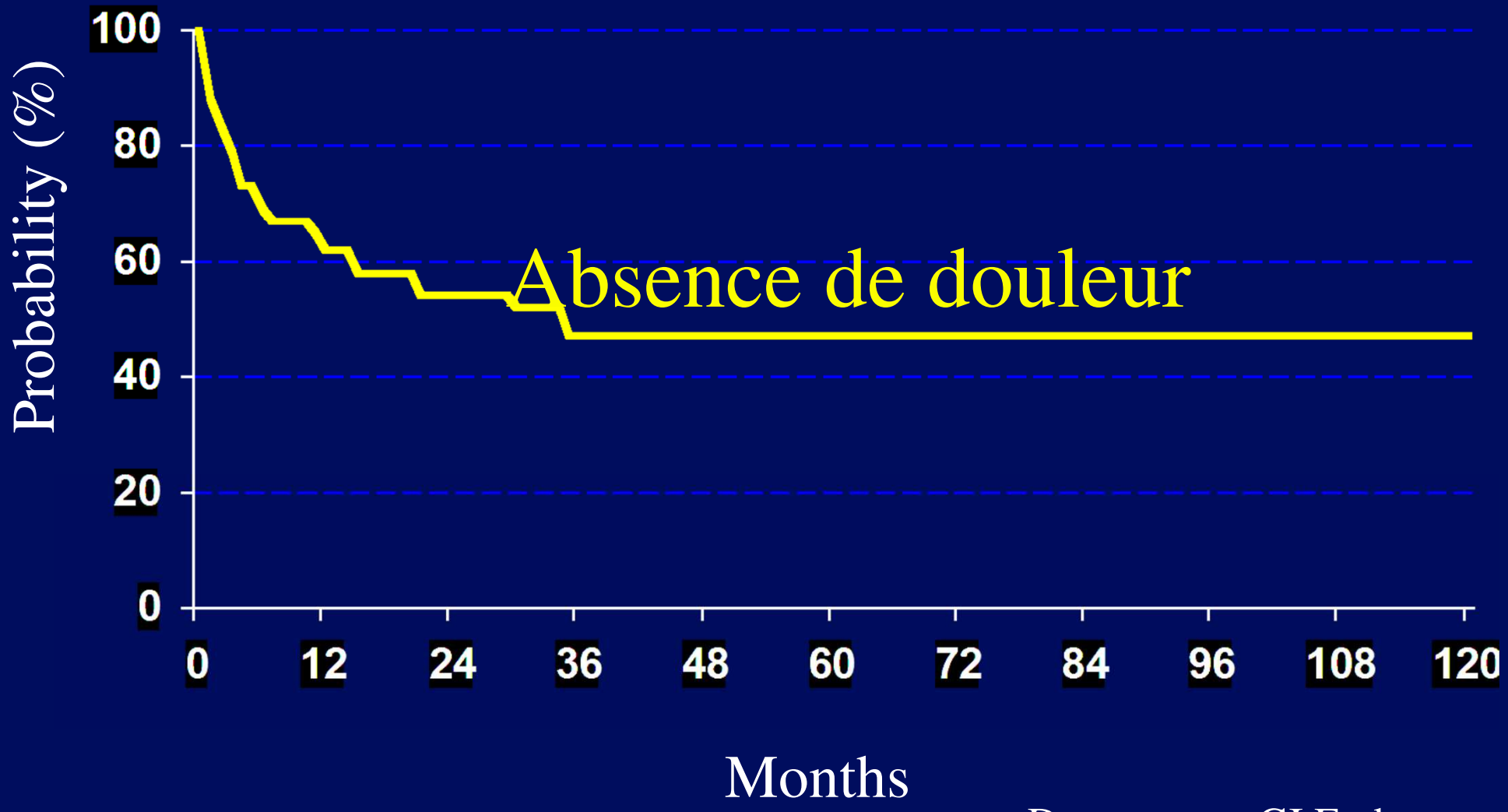
Before ESWL

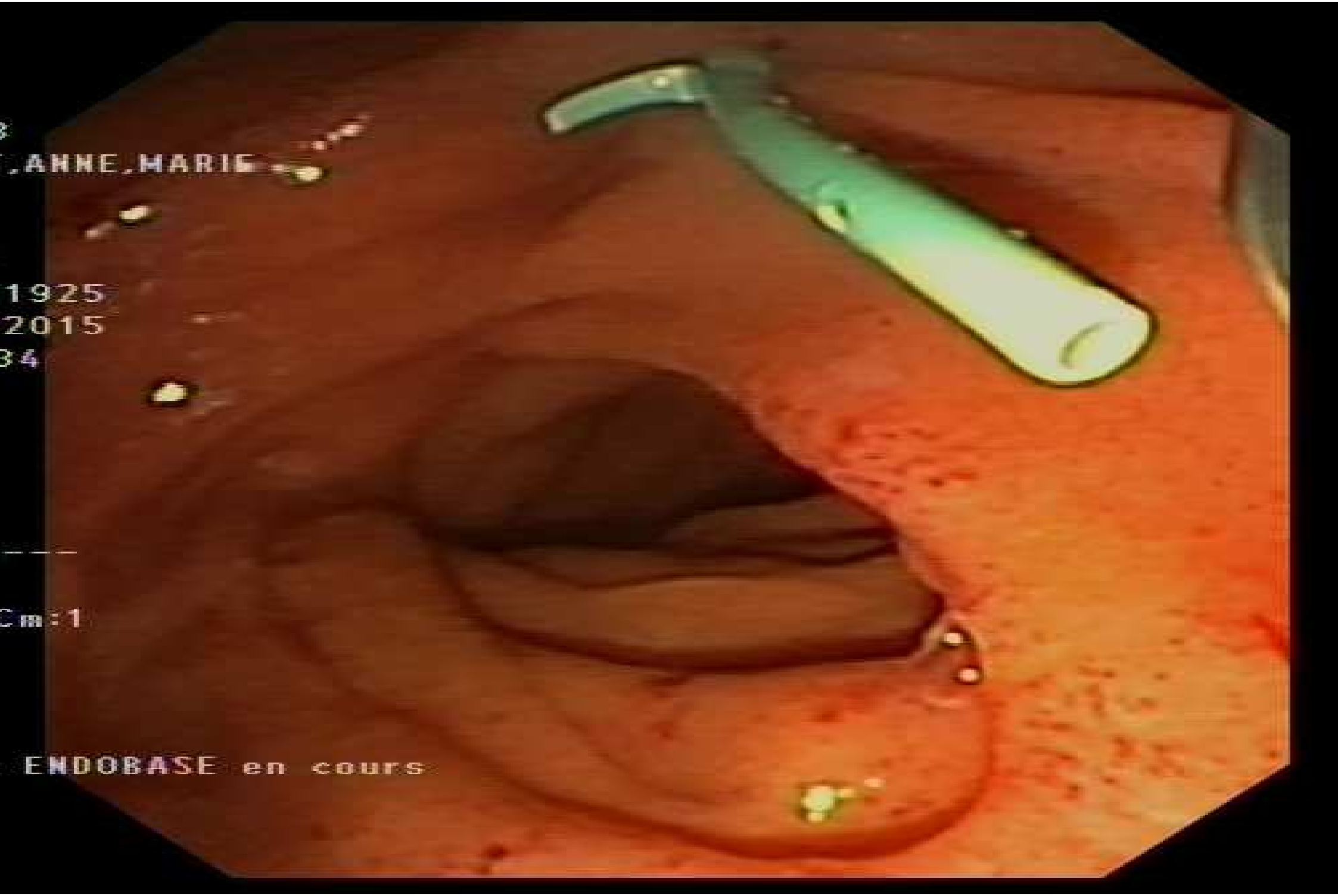
After ESWL

Résultats à long terme (N=58)



Dumonceau, GI Endoscopy 1996


.ANNE.MARIE
1925
2015
20
Cm:1
ENDOBASE en cours


ANNE,MARIE
1925
2015
34
ENDOBASE en cours

Chirurgie

- En cas d'échec de l'endoscopie
- Très peu d'études contrôlées, multiples techniques

---> Décompression

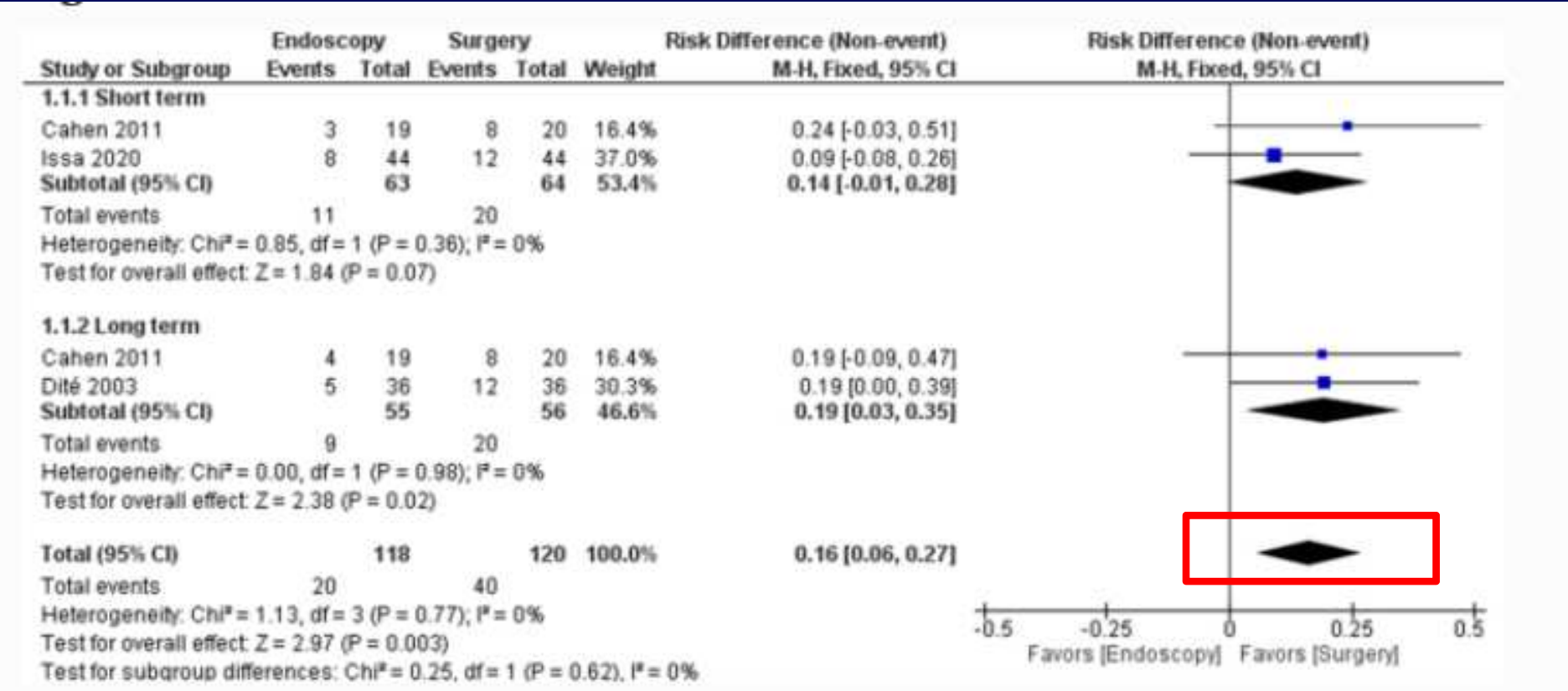
Short term pain relief : 80% des cas. Morbidité et mortalité 5%
Mais persistance symptômes dans 60% des cas sur un suivi de 2 ans

---> Résection

Pain relief dans 85% des cas

AGA technical review 2002

Pain relief in chronic pancreatitis: endoscopic or surgical treatment? a systematic review with meta-analysis



Surg Endosc. 2021

CONCLUSIONS

- Meilleure connaissance de la physiopathologie

- Nouvelles entités étiologiques

-Thérapeutique simple en apparence mais complexe en pratique

Digestive Surgery

Table 2. Summary of randomized controlled trials evaluating interventions in patients with CP

First author	Year	Interventions	Patients n	Mean follow-up months	Results	Risk of bias
Surgery						
Klempa [115]	1995	Beger vs. PD	43	36–66	Beger: less pain (100 vs. 70%), shorter hospital stay, better pancreatic function, equal mortality and morbidity	No allocation concealment, not powered, and no ITT analysis
Büchler [113]	1995	Beger vs. PPPD	40	6	Beger: more pain relief (75 vs. 40%) and better pancreatic function; comparable hospital mortality, overall morbidity, mean hospitalization time, and hospital readmission	No allocation concealment, not powered, and no ITT analysis
Izbicki [105]	1995	Frey vs. Beger	42	18*	Frey: less morbidity (9 vs. 20%); comparable pain relief (94 and 95%), increase in quality of life and pancreatic function	No ITT analysis
Izbicki [151]**	1997	Frey vs. Beger	74	30*	Frey: less morbidity (22 vs. 32%); comparable pain relief (93 vs. 95%), increase in quality of life and pancreatic function	No allocation concealment, not powered, and no ITT analysis
Müller [152]	1997	Beger vs. PPPD	20	26*	Beger: less frequent delayed gastric empting; comparable rates of pain relief, hospital readmission, and weight gain	No allocation concealment, not powered, and no ITT analysis
Izbicki [84]	1998	Frey vs. PPPD	61	24*	Frey: lower morbidity (19 vs. 53%), quality of life improvement (71 vs. 43%); equal pain relief (94 vs. 95%)	No ITT analysis
Farkas [114]	2006	Beger vs. OPPHR	40	12*	OPPHR: shorter operation time, less morbidity (0 vs. 40%), shorter hospital stay, and more increase in body weight; comparable hospital mortality, total relief of the symptoms (85 vs. 90%), pancreatic function, and hospital readmission	No allocation concealment, not powered, and no ITT analysis
Köninger [153]	2008	Beger vs. Bern	65	24	Berne: shorter operative time (46 min) and shorter hospital stay (11 vs. 15); equal quality of life; 3 patients in the Berne group were re-operated on during the follow-up period due to ongoing pancreatitis and bile duct obstruction	Low risk of bias
Long-term follow-up						
Strate [95]	2005	Frey vs. Beger	74	104*	Comparable pain relief, morbidity, mortality, quality of life, and pancreatic function	Long-term follow-up [151]
Strate [150]	2008	Frey vs. PPPD	46	84*	Comparable pain relief, quality of life, and pancreatic function	Long-term follow-up [84]
Müller [148]	2008	Beger vs. PPPD	40	168	No difference on the long term in terms of pain relief, quality of life, and pancreatic function	Long-term follow-up [113]
Endoscopy versus surgery						
Dite [13]	2003	Endoscopy vs. surgery	72	60	Surgery: higher complete or partial pain relief (86 vs. 61%), more increase in weight (47 vs. 29%) Surgery: 20% drainage vs. 80% resectional procedures Endoscopic therapy: without ESWL	Pseudo-randomization, no allocation concealment, not powered, lack of baseline characteristics, and no ITT analysis
Cahen [12]	2007	Endoscopy vs. surgery	39	24	Surgery: higher complete or partial pain relief (75 vs. 32%), better physical quality of life; comparable morbidity Surgery: pancreaticojejunostomy Endoscopic therapy: with ESWL	Low risk of bias
ESWL versus ESWL + endoscopy						
Dumonceau [33]	2007	ESWL vs. ESWL + endoscopy	55	24	Comparable results in terms of pain relapse and morbidity; treatment costs per patient were 3 times higher in the ESWL + endoscopy group	Low risk of bias

Dig Surg 2013;30:35–50

Endoscopic versus surgical drainage of the pancreatic duct in **chronic pancreatitis**.

Table 3. Outcomes of Endoscopic and Surgical Treatment after 2 Years of Follow-up.*

Variable	Endoscopy (N=19)	Surgery (N=20)	Endoscopic Results vs. Surgical Results (95% CI)	P Value
Izbicki pain score†	51±23	25±15	24 (11 to 36)‡	<0.001
Pain relief — no. (%)§	6 (32)	15 (75)	−43 (−72 to −15)¶	0.007
Complete relief	3 (16)	8 (40)		
Partial relief	3 (16)	7 (35)		
No relief	13 (68)	5 (25)		
Conversion to surgery — no. (%)	4 (21)	NA		
Technical success — no. (%)	10 (53)	20 (100)	−47 (−70 to −25)¶	<0.001
[illegible]	[illegible]	[illegible]	23 (−8 to 53)¶	0.15
Major	0	1 (5)		
Minor	11 (58)	6 (30)		
Death — no. (%)	1 (5)	0	5 (−5 to 15)¶	0.49
Hospital stay — median no. of days (range)	8 (0–128)	11 (5–59)	−3 (−9 to 4)‖	0.13
Hospital readmittance — median no. of patients (range)	1 (0–5)	0 (0–7)		
Procedures — median no. (range)	8 (1–21)	3 (1–9)	5 (2 to 8)‖	<0.001
Diagnostic	3 (0–11)	2 (0–8)		
Therapeutic**	5 (1–11)	1 (1–5)		
SF-36 quality-of-life scores††				
Physical health component	38±9	47±7	−8 (−13 to −3)‡	0.003
Mental health component	40±9	45±9	−3 (−8 to 1)‡	0.15
Exocrine function				0.05
Insufficiency persisted — no. (%)	11 (61)	13 (65)		
Insufficiency developed — no. (%)	6 (33)	1 (5)		
Insufficiency resolved — no. (%)	1 (6)	3 (15)		
Sufficiency persisted — no. (%)	0	3 (15)		
Fecal elastase — μg/g	56±74	145±189		
Endocrine function				0.48
Insufficiency persisted — no. (%)	3 (17)	4 (20)		
Insufficiency developed — no. (%)	3 (17)	1 (5)		
Insufficiency resolved — no. (%)	1 (6)	0		
Sufficiency persisted — no. (%)	11 (60)	15 (75)		
Serum glucose — mmol/liter‡‡	6.8±3.2	5.9±1.6		
Glycated hemoglobin — %	6.4±1.2	6.2±1.3		

N Engl J Med. 2007