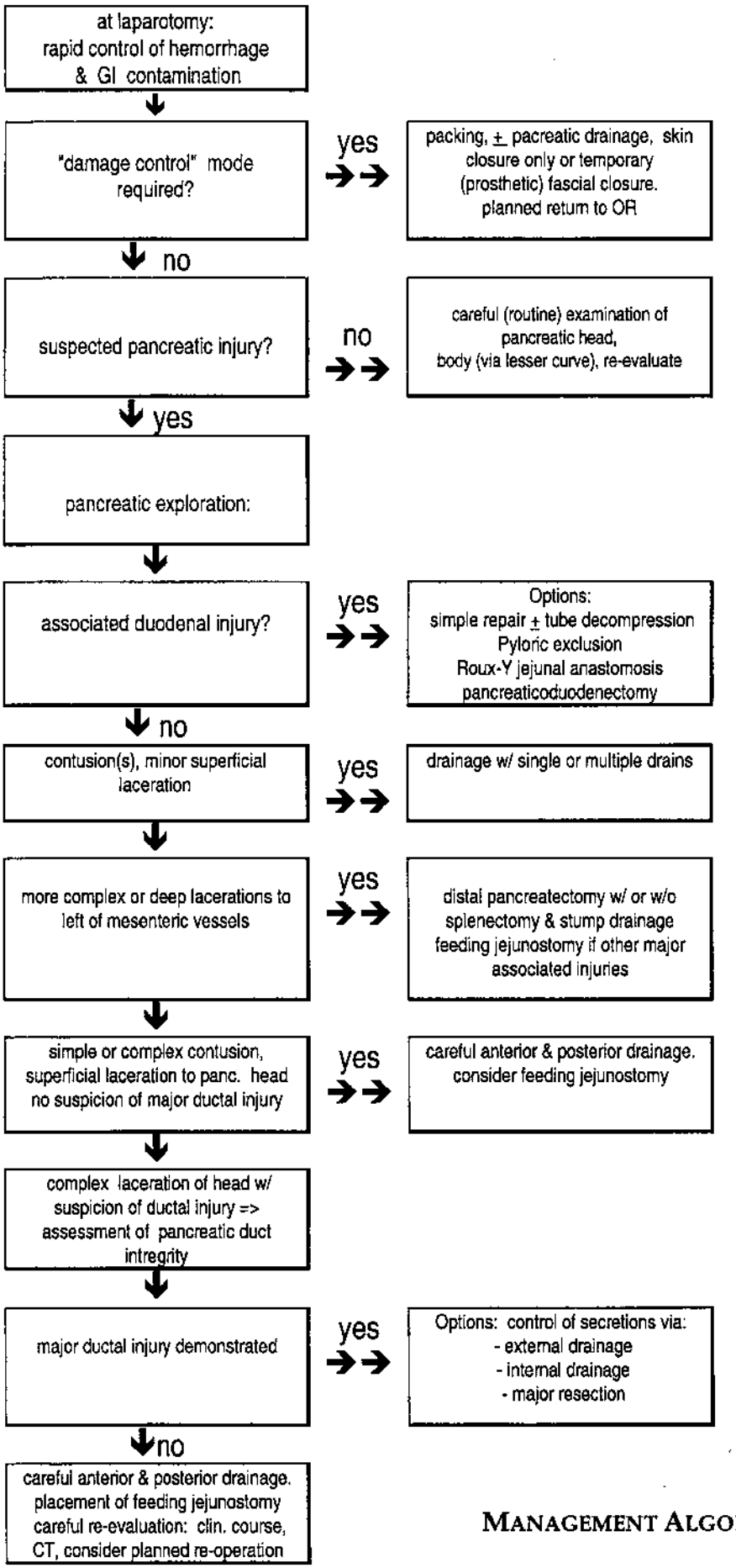

COMMENTS

Need for damage control base on:
- associated injuries (esp. liver/vascular)
- degree of acidosis
- degree of hypothermia
- degree of coagulopathy

Pancreatic injury suspected by:
- adjacent duodenal injury
- peri-pancreatic hematoma, any part
- local fat supponification (later)
- high, central retroperitoneal hematoma

Complete pancreatic exploration consists of:
- Wide Kocher manuver w/ eval of posterior head
- Full exploration of body through lesser sac
- Mobilization of spleen & tail (if needed)

ISSUE: How should treatment of pancreatic injury be modified based on associated duodenal injury? Pyloric exclusion has been a popular option for combined injuries. Roux-Y duodenojejunostomy useful for injuries w/ substantial loss of tissue.

Closed suction drains are probably preferred to open sump drains because of an observed reduction in bacterial (retrograde) contamination.

Decision to perform splenectomy should be based on anatomy (easy/hard), & associated injuries. Splenic preservation is feasible 40-50% of the time.

ISSUE: "Best" technique for stump closure: Stapled v. sewn. Absorbable vrs. non-absorbable suture material

The routine use of somatostatin for prophylactically decreasing the output/duration of pancreatic fistulas is probably not indicated. Data on somatostatin for post-traumatic high output fistulas is limited.

ISSUE: optimal method for pancreatic duct study?:
- on-table trans-duodenal pancreatography
- on-table ERCP
- drainage & post-op ERCP

ISSUE: "Best" option has not been identified:
- lay-on Roux-en-Y pancreaticojejunostomy
- careful placement of ant. + post. drains
- subtotal resection of head w/ roux-Y to distal stump
- Whipple-type resection (preserving pylorus)

MANAGEMENT ALGORITHM FOR PANCREATIC INJURIES