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Walled-off pancreatic necrosis: Wishing our pancreatitis nomenclature was correct

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Abstract

The ultimate reason why pancreatologists have strived to establish definitions for inflammatory pathologies of the pancreas is to improve patient care. Although the Atlanta Classification has been used for around for 17 years, considerable misunderstanding of the key elements of the nomenclature still persists. While a recent article by Stamatakos *et al* aimed to deal with an entity not clearly defined in the 1993 document, it is replete with factual and conceptual errors as well as contradictory statements.

Key words: Severe pancreatitis; Acute necrotizing pancreatitis; Walled-off pancreatic necrosis

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TO THE EDITOR

I am puzzled as to why the editorial process did not identify the multitude of major factual and conceptual errors in the article "Walled-off pancreatic necrosis" by Stamatakos *et al*[1]. Without consistency in terminology among experts, our patients will not benefit from high-quality studies such as the Dutch PANTER trial which showed a reduction in morbidity of infected pancreatic necrosis managed with a step-up percutaneous approach compared with the Berger technique of open necrosectomy[2]. Walled-off pancreatic necrosis (WOPN) refers to (peri)pancreatic necrosis in a patient who has been nursed through 10-12 wk of illness and presents with pressure symptoms or rarely with infection[3]. This time-dependent maturation results in separation and demarcation of the solid component and sometimes liquefaction[3].

The authors have been permitted to perpetuate the misconception that a pancreatic pseudocyst contains necrosis when the Atlanta Classification clearly states that it does not[4].

Statements such as the following indicate that the authors do not understand the term of wall off pancreatic necrosis: "WOPN was formerly known as pancreatic abscess", "WOPN occurs … in complicated cases of pseudocysts", "little or no necrotic material is present", "superinfection of pseudocysts is one way that WOPN may develop" and "bacterial flora … is the sine qua non of WOPN". The authors stated that WOPN was defined in 2005 but have referenced articles from 2001 and 1993 when outlining the epidemiology and pathophysiology of this condition.

The authors seem confused about patient outcome from severe pancreatitis: the greatest predictor of mortality is deteriorating organ dysfunction rather than the extent of

necrosis or infection[5]. On the one hand, they stated that "mortality rate approaches 100% if surgical intervention … (is) not undertaken for WOPN". On the other hand, they stated that "if bacteremia can be restrained, necrosectomy can be avoided".

With disregard for current evidence, the authors recommended total parenteral nutrition[6] and prophylactic antibiotics[7] for patients with severe pancreatitis.

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