Pancreatic sphincterotomy and sphincteroplasty

History and definitions
In 1681 Glisson described a sphincter at the end of the common bile duct, which allowed bile to flow intermittently into the duodenum.\(^1\) Exactly 200 years later, Oddi portrayed the sphincteric mechanism in greater detail,\(^2\) but it was not until 1957 that Boydén unravelled the complexity of the anatomical sphincter surrounding the terminus of the common bile duct and pancreatic duct.\(^3\) Although the surrounding duodenal musculature can compress the distal end of both ducts, there is a more important sphincter that acts independently. Boydén showed a submucosal muscular sheath which surrounds the intramural portion of both ducts, and the two ducts are separated by a thin veil of tissue, the septum.

Clinical application of this knowledge began in 1956 when Doublet and Mulholland published the results of biliary sphincterotomy for recurrent pancreatitis, which they thought resulted from reflux of bile into the pancreatic duct.\(^4\) Believing that outflow obstruction was more important than reflux, Bartlett and Nardi\(^5\) extended the operation by dividing the common septum between the terminal bile duct and pancreatic duct, thereby achieving a pancreatic sphincterotomy in addition. Subsequently, Moody and colleagues actually excised this common septum (transampullary septectomy or extended papillotomy) in 92 patients with disturbing postcholecystectomy pain, 85 of whom were found to have stenosis of the origin of the duct of Wirsung.\(^6\) We have recently undertaken a modified pancreatic sphincteroplasty in a small series of patients with pancreatic or papillary disease.\(^7\) The first endoscopic cannulation of the papilla of Vater by McCune in 1968 opened a new era in the diagnostic approach to pancreateobiliary disorders.\(^8\) Six years later this purely diagnostic technique was adapted to become a therapeutic modality by the introduction of endoscopic biliary sphincterotomy,\(^9\) followed by other treatment modalities including pancreatic sphincterotomy.\(^10\)

The term 'sphincterotomy' means division of the mucosa and underlying sphincter mechanism, a procedure that can now be achieved either endoscopically or by transduodenal surgery. 'Sphincteroplasty' indicates mucosa-to-mucosa suture, either duodenum to bile duct alone (biliary sphincteroplasty) or bile duct to pancreatic duct in addition (pancreatic sphincteroplasty). Both procedures produce permanent destruction of the sphincter mechanism. Sphincteroplasty offers the theoretical advantage of preventing restenosis, but at present it can only be achieved by an open operation of some technical complexity. This paper reviews the indications for division of the pancreatic sphincter, both at the major and minor papilla, and the endoscopic and surgical means by which this can be accomplished.

Indications

Postcholecystectomy pain
Persistence or recurrence of symptoms after cholecystectomy is common but sometimes difficult to evaluate and treat. Extrapancreatic disease must be excluded by thorough investigation of the alimentary, hepatopancreatobiliary and urinary tracts. The contributions of emotional overlay and of alcohol and analgesic abuse may need to be disentangled. Thus selection of the small number of patients who will benefit from pancreatic sphincteroplasty is not straightforward, and the operation should probably be reserved for those with papillary stenosis involving the pancreatic ductal orifice. Even then, lasting benefit cannot be guaranteed.\(^11\) Three tests can help to confirm organic papillary disease, though their precise role remains to be established.

Endoscopic retrograde cholangiopancreatography and manometry
Endoscopic retrograde cholangiopancreatography (ERCP) is an important part of the investigation of patients with upper abdominal pain of biliary or pancreatic distribution. Repeated failure by an experienced endoscopist to cannulate either the bile duct or the pancreatic duct may be a clue to anatomical abnormality. Likewise, delayed clearance of contrast from either ductal system or reproduction of typical pain during ERCP may also indicate outflow obstruction. Although ERCP alone is not accurate in predicting the results of pancreatic sphincteroplasty,\(^12\) coincident manometry can provide additional information. Manometric pressure measurements are recorded within the sphincter of Oddi, common bile duct, pancreatic duct and duodenum. The examination requires a cooperative patient and a skilful endoscopist, who can pass a soft manometry catheter through the papilla into the common bile duct and pancreatic duct, manipulate the catheter parallel with the axis of the appropriate duct and maintain a stable position during the recording period. As experience increases, a few centres are now reporting success rates of 70–100% in measuring pancreatic sphincter pressure.\(^12\) The predictive value of ERCP manometry remains unproved, but accurate pressure recordings across the sphincter should provide logical criteria on which to base the decision to operate.
Morphine-prostigmine (Nardi) evocative test
This test consists of an intramuscular injection of 10 mg morphine plus 1 mg prostigmine (neostigmine). Serum amylase (and lipase) are measured both before and (hourly) for four hours after the injection. The test is considered positive if the injection reproduces pain and causes a fourfold increase in serum enzyme concentrations. In our limited experience the test has been helpful in predicting a satisfactory outcome from pancreatic sphincteroplasty in patients with postcholecystectomy pain, and the operation certainly abolishes the enzyme response to morphine-prostigmine.8 The test can be positive in patients without pancreatobiliary disease, however, and Moody found it a poor predictor of outcome after ablation of the sphincter.13

Secretin stimulation during pancreatic ultrasonography
Another product of the Massachusetts General Hospital is the secretin stimulation test, which can be used for patients with suspected papillary stenosis. According to Warshaw and colleagues, the test is positive if there is prolonged dilatation of the pancreatic duct for 15–30 minutes after intravenous administration of secretin (1 mg/kg).7 The pancreatic duct dilated up in 10 of 12 symptomatic patients who were later found to have a stenotic sphincter but in none of 10 patients without operative evidence of stenosis. A positive test predicted a good result from surgical sphincteroplasty (in 90% of patients) and, like the Nardi test, the operation subsequently rendered the test negative.7 It can be difficult to identify a normal size pancreatic duct by ultrasound, but modern computed tomography scanners could offer an alternative means of conducting the test.

RECURRENT ACUTE PANCREATITIS
In younger patients who do not abuse alcohol, recurrent attacks of acute pancreatitis require active investigation to seek underlying causes such as occult gall stones and metabolic disorders (hyperlipidaemia, hypercalcaemia). Stenosis may be encountered at either the major or the minor papilla, especially in patients with atypical variants of the pancreatic ductal tree. Classical pancreas divisum with separate dorsal and ventral ducts is the most common variant. It occurs in approximately 5% of population,16,17 but the incidence increases to 10–25% among patients with unexplained recurrent pancreatitis.19,20 Less common anomalies include incomplete pancreas divisum, in which the communication between dorsal and ventral ducts is tiny and functionally inadequate, and a variation in which only the dorsal ductal system is found, the ventral duct having probably regressed. Major papillary stenosis can cause recurrent acute pancreatitis, whether the ductal pattern is normal8 or there is pancreas divisum.12 Sphincteroplasty of the main pancreatic duct prevented recurrent attacks of acute pancreatitis in five of our patients with a normal disposition of ducts but probable papillitis at a median follow up of 18 months.8

To develop pancreatitis, patients with pancreas divisum must probably also have minor papillary stenosis, so that the bulk of exocrine secretion is forced to flow through a site of partial obstruction. Under these circumstances accessory pancreatic sphincteroplasty can prevent further attacks of acute pancreatitis, and we have successfully treated five such patients. Warshaw’s 100 patients with ‘dominant dorsal duct syndrome’ includes 71 with classical pancreas divisum, 23 with only a dorsal duct and six with a filamentous connection between the two ducts. Forty nine had recurrent acute pancreatitis, while 51 had chronic pain alone. Among 88 patients undergoing accessory pancreatic sphincteroplasty, the operation was 85% successful, as assessed by the absence of further attacks of pancreatitis or pain and freedom from narcotic usage, if the accessory papilla was stenotic; in the absence of stenosis the operation was only 27% successful.12

There was a close correlation between the result of an ultrasound secretin test and a successful postoperative result in Warshaw’s patients with recurrent pancreatitis:12 90% of those with a positive test were improved, whereas 60–70% of those with a negative test had a poor result. ERCP manometry may also be useful in identifying a subgroup of patients with clear cut sphincter dysfunction, affecting either the major part of the sphincter of Oddi (ampullary sphincter) or the pancreatic sphincter or both. Most patients with raised basal pressures will benefit from endoscopic or surgical ablation of the sphincter.14 An endoscopic stent was placed recently across the major papilla in 15 patients with recurrent pancreatitis with or without raised basal pressures. There was one technical failure, but only eight of the other 14 patients (57%) were improved.21 Better results were obtained among 31 patients with pancreatitis and pancreas divisum who received an endoprosthesis into the dorsal pancreatic duct:14 92% were improved, though 26 patients subsequently required pancreatic surgery (either accessory sphincteroplasty or resection) for recurrent symptoms. Those who improved with endoscopic drainage had better postoperative results than those who did not.

If preoperative stenting of the pancreatic duct can help select patients with recurrent pancreatitis for operation, the Nardi test is less reliable in this group20 and may even be dangerous. A single experience of necrotising pancreatitis in a patient with a slight rise in basal serum amylase had led us to avoid stimulating the pancreas in such circumstances and to terminate the test with atroine if severe pain develops.25 Our present policy is to recommend exploratory laparotomy in nearly all patients with repeated attacks of ‘idiopathic’ acute pancreatitis. Tiny gall stones and/or cholesterolosis of the gall bladder may be missed by any other technique. If the gall bladder is healthy we usually proceed to double sphincteroplasty (biliary and pancreatic) when the pancreatic ductal system is normally disposed or to accessory pancreatic sphincteroplasty if there is pancreas divisum. The full disposition of the pancreatic ductal tree should be delineated by on-table pancreateography28 if ERCP was incomplete.

CHRONIC PANCREATITIS
Chronic pancreatitis is an uncommon indication for pancreatic sphincteroplasty. Indeed in severe disease it has little or no role. In a few patients with mild disease and an apparent stenosis of the pancreatic duct adjacent to the papilla, pancreatic sphincteroplasty may be beneficial.4,8 Some patients with unequivocal chronic pancreatitis have symptoms dominated by recurrent pain and raised serum amylase, and in these a timely sphincteroplasty might relieve pain and prevent progressive fibrosis. In those with alcohol related disease, however, abstinence is likely to be much better than prophylactic sphincterotomy. There is increasing interest in managing selected patients with endoscopic techniques, including pancreatic sphincterotomy, stenting of the duct and calculus extraction.27,31 Although good results are claimed, these manoeuvres seem unlikely to achieve anything other than temporary success in patients with established chronic pancreatitis.

Techniques and results
MAJOR PAPILLARY SPHINCTER
 Interruption of the pancreatic sphincter mechanism can be achieved by either an endoscopic or a surgical approach. Endoscopic sphincterotomy of the pancreatic duct (endoscopic septotomy) is usually performed together with biliary
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The operation is safe, and in carefully selected cases it can be extremely effective.

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