Erratum

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In the article “Nerve Blocks and Neuroablative Surgery for Chronic Pancreatitis,” by Edward L. Bradley III and Jiri Bem, Table 1 and the text referring to it did not appear in its complete form. The referring text, Table 1, and the complete citations for additional references in Table 1 appear below.

The collected experience with thoracoscopic splanchnicectomy for chronic pancreatitis is shown in Table 1. The overall rate of subjective improvement in the perceived level of pancreatic pain was 85.5% in a group of 248 patients followed an average of 22.2 months. Improvement was defined as a postoperative decrease in VAS pain, a decrease in narcotic usage, or some combination of both. Interestingly, unilateral splanchnicectomy failed to improve pain in 17 of 46 cases (36.9%), while bilateral splanchnicectomy

failed in only 19 of 180 cases (10.6%) ($p < .01$). Moreover, no criteria could be identified to predict success or failure of unilateral splanchnicectomy. Sixteen of the 17 patients failing unilateral splanchnicectomy underwent subsequent contralateral splanchnicectomy, and 10 of these 16 were improved. These results suggest that if unilateral splanchnicectomy is chosen, a low threshold for staged contralateral splanchnicectomy should be maintained. Based upon our discussion of neuroanatomy, we believe that mid-line pain is an indication for bilateral splanchnicectomy as the original procedure. Taking all of these collected data into account, it seems fair to conclude that splanchnicectomy can significantly reduce pain for variable periods in some, but not all, patients with chronic pancreatitis.

Table 1. Trans-thoracic splanchnicectomy for intractable pain from chronic pancreatitis.

Author (Reference)	Year	Patients (re-operations)	Approach to splanchnicectomy	Failed	Improved	Complications (number)	Mean follow-up (months)
Stone and Chauvin [32]	1990	15	Left thoracotomy; left splanchnicectomy; bilateral vagotomy	6	9	Delayed gastric emptying (11)	16
		(5 ^a)	Right thoracotomy; right splanchnicectomy	1	4		
Cuschieri et al. [33]	1994	5	Bilateral thoracoscopic	2	3	None	8
Andren-Sandberg et al. [34]	1996	14	Bilateral thoracoscopic	1	13	Intrathoracic bleeding requiring exploration (3)	16
						Intercostal neuralgia (1)	
Maher et al. [22]	1996	8	Unilateral thoracoscopic	7	1	Intercostal neuralgia (“many”)	18
		7	Bilateral thoracoscopic	0	7	Chylothorax (1)	
Bradley et al. [16]	1998	(7 ^a)		3	4	Orthostatic hypotension (4)	
		2	Open thoracotomy	1	1	Atelectasis (6)	23
		8	Unilateral thoracoscopic	4	4	Intercostal neuritis (1)	
		6	Bilateral thoracoscopic	3	3	Focal hyperesthesia (1)	
Totals		(4 ^a)		2	2		
		65		14 ^b	51 (78.4%)		16.2
Moodley et al. [38]	1999	17	Bilateral thoracoscopic	1	16	Pneumothorax (1)	12
Ihse et al. [39]	1999	21	Bilateral thoracoscopic	2	19	Intra-thoracic bleeding (2)	43
						Transient intercostal neuralgia (1)	
Imrie et al. [40]	1999	14	Bilateral thoracoscopic	0	14	Intra-thoracic hemorrhage (1)	12
Buscher et al. [41]	2002	44	Bilateral thoracoscopic	11	33	Pneumothorax (2)	36
						Intercostal neuralgia (3)	
Howard et al. [42]	2002	55	Bilateral thoracoscopic	8	47	Chylothorax (3)	32
						Wound infections (2)	
Makarewicz et al. [43]	2003	32	Unilateral thoracoscopic (31)	0	31	None	12
			Open thoracotomy (1)		1		
Totals		248		36	212 (85.5%)		22.2

^aFailures of unilateral splanchnicectomy requiring contralateral splanchnicectomy.

^bOf 17 patients who experienced failure after unilateral splanchnicectomy, 16 underwent contralateral splanchnicectomy, and 10 of them improved.

References

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