Response to Letter to the Editor: Reflux Esophagitis and Marginal Ulcer After Pancreaticoduodenectomy

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We thank Dr. Selina Buchner et al. for their careful review and thoughtful comments on our recent article.¹ First, we apologized for the mistake of inconsistent data in the result and discussion part. The correct result is listed below. There are 158 patients undergoing PD in our study, including 109 PD with uncut roux-en-Y method and 49 conventional antecolic gastrojejunostomy. There are seven reflux esophagitis after uncut R-Y method ($n=109$) and eight reflux esophagitis after conventional antecolic gastrojejunostomy ($n=49$). The P value is 0.042. On the other hand, there were 213 patients receiving PPPD, including 157 PPPD with uncut roux-en-Y method and 56 PPPD with antecolic duodenojejunostomy. There are 16 reflux esophagitis after uncut roux-en-Y method ($n=157$) and 9 reflux esophagitis after antecolic duodenojejunostomy method ($n=56$).

About the diagnosis of patients in our study, there are 261 cancer, 42 chronic pancreatitis, and 68 benign pancreatic diseases. There are 116 (73.4%) cancer patients receiving PD, and 145 (68.1%) cancer patients undergoing

PPPD. Actually we found recannulation of the afferent loop after TA staplers proved by a Hypaque flow study or surgical findings for another laparotomy before. As a result, we routinely put additional two rows of 2-0 silk horizontal mattress sutures above and below the TA staplers line to prevent recannulation of afferent loop. We believe that the incidence of recannulation was very low after the above procedures. If fistula through the intestinal block by the TA staplers is suspected, the integrity of the intestines may be checked by endoscope or UGI series. Nevertheless, we do not routinely arrange image study or endoscopy to check the afferent loop.

References

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