

Editorial: Does ESWL-ERCP for pancreatic duct stone removal change the natural course of symptomatic chronic calcific pancreatitis?

As someone who has performed extracorporeal shock wave lithotripsy and endoscopic retrograde cholangiopancreatography (ESWL/ERCP) for obstructing pancreatic duct (PD) stones for over 3 decades, I was intrigued to review the experience by Liu et al.¹ from the largest pancreatic referral centre in China. Retrospectively reviewing over 2000 patients with chronic pancreatitis (CP) enrolled in a prospective database between 2011 and 2018 (mean follow-up 6.7 years), they report complete stone extraction in approximately 74% of patients. In the prospective portion of this mixed observational study (9/2023–3/2024), there was significant improvement in patient-reported outcomes and complete pain remission in 70% of patients. The authors also documented a transition from patients' original presentation (2/3 recurrent pain or recurrent acute pancreatitis and another 27% with both). Study limitations include failure to measure faecal elastase, which underestimates exocrine pancreatic insufficiency. Moreover, the incidence of recurrent stones and pseudocysts is likely higher as 719/1843 (39%) patients in the prospective portion did not undergo CT or MR imaging. Nevertheless, only 8.8% of patients underwent further invasive treatment, which is impressive and surpasses published experience from our institution in which 85% of our patients had improved quality of life post-treatment at a mean follow-up of 4.8 years.² However, all patients were taking narcotics at baseline, and despite narcotic reduction, only 50% were completely pain-free. Moreover, 29% underwent an interval ERCP (84%) or pancreatic surgery (16%). The current study also surpassed the outcomes of multiple randomised controlled trials comparing ESWL-ERCP to pancreatic surgery for refractory pain or recurrent clinical pancreatitis.^{3–5}

Why this discordance? Sixty percent of the patients in the current series were classified as idiopathic CP (? smoking^{6–8}), and in contrast to most Western series, <30% were alcohol related. Moreover, only 9.2% took analgesics prior to ESWL-ERCP and only 4% complained of chronic pain. Finally, in contrast to most other series in which stones were associated with PD strictures, 50% of patients had isolated main PD stones without strictures. This suggests that either CP may be

different in Asia or that patients were treated earlier in the course of their disease. The fact that 20% had clinical steatorrhoea and a quarter were diabetic at enrolment does not answer this question, nor does the subsequent development of new diabetes or clinical steatorrhoea in an additional 18% at follow-up.

Perhaps this population is comparable to that reported by the Asian Institute of Gastroenterology which has reported their experience in over 5000 patients.⁹ If so, we should all reassess our outcomes as this group's most recent prospective, randomised and sham-controlled trial of ESWL-ERCP, demonstrated statistically significant pain relief at 12 weeks based on a 10-point visual analogue score.¹⁰ Secondary outcomes including a 30% pain reduction, decrease in pain-free days, and opioid use were no different at 12 or 24 weeks when comparing the sham to the treated group. The placebo response to any intervention is real. However, maintaining that response for the 6.7 year mean in the current study by Liu et al seems unlikely given the absence of pain in the majority of treated patients.

AUTHOR CONTRIBUTIONS

Richard Kozarek: Conceptualization; investigation; formal analysis; writing – original draft; writing – review and editing.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

LINKED CONTENT

This article is linked to Yiu et al papers. To view these articles, visit <https://doi.org/10.1111/apt.18224> and <https://doi.org/10.1111/apt.18284>

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