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Comments on Quality of Life in Patients With Definite Chronic Pancreatitis: A Nationwide Longitudinal Cohort Study

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We read with great interest the recently published study on "Quality of life in patients with definite chronic pancreatitis: a nationwide longitudinal cohort study" (1). The study is valuable, yet we found some points requiring further clarification.

First, common complications in patients with long-standing chronic pancreatitis (CP) include pancreatic pseudocysts, common bile duct stricture, and pancreatic stones, and the 10-year incidence of these complications after onset of CP are 13.5%, 12.4%, and 59.7%, respectively, according to our previous published cohort studies. These complications act as important covariates to affect physical (PCS) and mental (MCS) component summary scales because of the complications-related symptoms including abdominal pain, fever, jaundice, or upper gastrointestinal hemorrhage. Frequent hospital visits caused by these complications can increase patients' financial burden, which in turn has a significant impact on patients' quality of life. Moreover, pancreatic cancer is a severe complication of CP with the cumulative risk of 1.8% at 10 years and 4% at 20 years after diagnosis of CP (2). Patients with pancreatic cancer have poor quality of life because of the series of cancer-related conditions including dyscrasia and psychosocial impact. A case-control study noted that geriatric patients with pancreatic cancer have a poorer PCS scale (36.3 vs 29.3) and MCS scale (49.9 vs 44.8) compared with controls without cancer (3). Thus, it is better to include these CP-related complications in the univariate and multivariate analyses.

Second, patients with pancreatic cancer who have been misdiagnosed to have CP should be excluded from this study. According to previous research, approximately 5% of patients with pancreatic cancer were initially misdiagnosed to have CP within 2 years (4), and some studies have set the time interval between the diagnosis of CP and pancreatic cancer at more than 5 years to further reduce the misdiagnosis. Pancreatic cancer within 2 years after the diagnosis of CP was not exhibited in this study or was excluded from this study, causing bias to the PCS and MCS scales. Therefore, excluding patients diagnosed to have pancreatic cancer during the first 2 years of follow-up would help purify the study group.

Third, only assessing pancreatic interventions performed ≤6 months before follow-up may have influenced the results. Many research studies have confirmed the long-term efficacy of interventions for CP. For example, a randomized clinical trial reported that the PCS and MCS scales increased from 31 to 36 and 36 to 41, respectively, at the 18-month follow-up after endoscopic therapy, and these scales were 35–39 and 38 to 44, respectively, in the surgery group (5). Thus, we think it is necessary to collect the interventions patients received during the whole time interval between every follow-up. In addition, we advise that the item "endoscopic treatment/surgery ≤ 6 months prior to the follow-up questionnaire" in univariate and multivariate analyses could be replaced by "endoscopic treatment/surgery during follow-up."

In summary, this research is valuable and has important implications for guiding clinical practice while further works including variables' inclusion and patients' exclusion could be made to perfect the results.

CONFLICTS OF INTEREST

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Response to Yi et al

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