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Invited Commentary

Surgery-First for Painful Chronic Pancreatitis

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The treatment of painful chronic pancreatitis (CP) with a dilated pancreatic duct has often included early endoscopy to decompress the duct by stents, while surgery has been saved as a last resort. However, recently at least 3 randomized clinical trials have challenged this step-up approach and demonstrated superiority of early surgery over first-line endoscopy.[1-3] Yet, clinical practice and guideline recommendations seem be slow to reflect this change in evidence.[4,5] As endoscopical procedures are usually performed by gastroenterologists (and surgery obviously by surgeons), the debate between the 2 first-line treatment options is also a debate between the specialties, both looking at the evidence from their own perspectives and incentives. As Abraham Maslow wrote: "It is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."

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In this issue of *JAMA Surgery*, Van Veldhuisen et al[6] report long-term outcomes of the ESCAPE trial. The results strongly support early surgery in treating painful CP as patients who had surgery first had lower pain scores, higher rate of complete pain relief, increased satisfaction, less reinterventions, and similar rates of exocrine and endocrine insufficiency. The initial ESCAPE trial,[3] with 18 months follow-up, did not find a clear benefit of surgery compared with patients in whom complete ductal clearance was achieved using endoscopic means. This might have affected the broad perception

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that endoscopy could still be a first-line approach. As perhaps the most important finding of this long-term follow-up study, surgery was still superior to endoscopy even if ductal clearance was achieved, let alone if the endoscopy failed.

Although we congratulate the authors,[6] some limitations of the study should be noted. First, the long-term follow-up was not predetermined or structured, leading to varying time points of data collection. Second, the recruitment period was extensively long, 7.5 years in 30 hospitals. With 88 randomized patients, this means that, on average, each hospital recruited 1 patient every other year. The question remains whether this indicates low incidence of CP in the Netherlands or high selection of patients in the trial. In any case, results from low-volume endoscopic units might not be applicable to high-volume dedicated advanced endoscopy units with high caseloads of pancreatic duct interventions.[7] Furthermore, the current study only partially takes into account the most recent developments in endoscopic techniques. Lastly, a relatively large number of patients undergoing early surgery required reintervention for biliary obstruction. The initial surgical technique should be accommodated with this in mind.

Now, 3 randomized clinical trials report benefit of surgery-first over endoscopical approach in treating painful CP. There's a famous Einstein quote: "Insanity is doing the same thing over and over and expecting different results." What is needed now is clinical implementation of the evidence.

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