INTRODUCTION

Chronic pancreatitis is defined as a chronic inflammatory disease, characterised by irreversible, progressive destruction of pancreatic tissue, with dynamic progressive fibrosis of pancreas, leading to progressive loss of both exocrine and endocrine function. Until the 1940s, it was thought to be a rare disease; knowledge of its natural history was fragmentary; and it was usually recognised only at autopsy. In 1946 and 1948 Comfort and his associates at the Mayo clinic gave the first, comprehensive clinical and pathological description of the disease and emphasized its association with diseases of the biliary tract and with alcoholism. The publication of these papers, along with the introduction of the secretin test of exocrine pancreatic function, led to the clinical diagnosis of increasing number of patients with chronic pancreatitis, and to a proliferation of various surgical procedures for this condition. The second milestone was reached in 1963 during a symposium of European gastroenterologists in Marseilles, where a simple classification of chronic pancreatitis was adopted, that replaced a bewildering array of terms and definitions, and has since been widely accepted.

AIM OF THIS STUDY

1. To recognise the various causative factors responsible for the disease process,
2. To analyse the various methods of presentation of chronic pancreatitis,
3. To evaluate the various indications for surgical interventions, and
4. To assess the results of surgical treatment.
MATERIALS AND METHODS

The patients admitted in Thanjavur Medical College Hospital, Thanjavur, during the period from September 2016 to August 2017, and their subsequent follow up at our outpatient department were studied. Their history, clinical presentation, investigations and management were recorded. From these data, the various aspects of chronic pancreatitis were studied.

The following investigations were done for diagnosis and evaluation of chronic pancreatitis.

- Urine sugar
- Blood sugar
- Serum calcium
- Amylase
- Plain X-ray abdomen
- Ultrasonogram abdomen
- CT-abdomen

OBSERVATION

The mean age of presentation in our study was 38.45 yrs, which correlates well with most others studies.

1. 10-20 years - 2

2. 21-30 years - 5
3. 31-40 years - 5

4. 41-50 years - 9

5. >51 years - 3

In our study, the age of the youngest patient was 17 years and the oldest was 53 years.

Sex

In our study, there were 19 males and 5 females, giving a sex ratio of 4:1, in favour of males. The sex ratio of 4:1 was also confirmed by a study conducted by Anand B.S in Delhi.

Religion

Among the 24 patients, majority belonged to the Hindu community (22/24), one from Christian, and one from Muslim community.

INCOME

One of the causes attributed for chronic pancreatitis in the tropics was protein-energy malnutrition as the disease is found generally in the low income group. Almost all the patients in our study belong to the lower socio economic group. This could be because of the referral bias, the affluent seeking treatment at private hospitals.
Alcoholic chronic pancreatitis accounted for 66.6% of the cases (16/24). Tropical pancreatitis accounted for 16.6% of the cases (4/24). In our study, the sex ratio was 1:1. In the rest of the cases (4/24), since no etiological factors could be found out, these patients were grouped under idiopathic chronic pancreatitis.

Pain was the outstanding symptom in the great majority (22) of patients (91.6%), 6 patients (25%) had diabetes mellitus, 2 patients had steatorrhoea (8.3%). 5 patients presented with abdominal pain and abdominal fullness / lump (20.8%)

Plain x ray abdomen revealed pancreatic calcification in 9 patients (37.5%). Ultrasonogram and CT scan revealed a dilated main pancreatic duct in 9 patients.

**Management**

Not all patients with chronic pancreatitis require surgery and half of the patients in many reported series have been managed conservatively. But in our study only 9 out of 24 (37.5%) patients were treated conservatively. This may be because of referral bias to our surgical department, ie., these patients were first treated medically and subsequently referred to surgical side following failure of medical management. Of the 24 patients, 9 patients had dilated main pancreatic duct. Of these 9 patients, 3 were managed conservatively and the rest (6 patients) underwent pancreaticojejunostomy. 8 patients with pseudocyst of the pancreas, with history and investigations suggestive of pseudocyst developing in chronic pancreatitis, underwent cystogastrostomy. Patients developing pseudocyst of the pancreas as a result of acute pancreatitis were not included in our study.
Percutaneous celiac plexus block was done in one patient with 6% phenol. Patient had good postoperative pain relief, but he developed paraperesis which resolved gradually. During our short follow-up of operated patients, almost all patients experienced appreciable pain relief. Our patients were not encouraged to expect significant improvement in exocrine and endocrine function after surgery.

Three of operated patients developed minimal wound infection, which was easily controlled. Resection operation was not done, as none of our patients suited the indications. In our series of 24 patients, we did not come across any case of chronic pancreatitis due to gallbladder disease.

CONCLUSION

Though chronic pancreatitis is not a surgical disease primarily, surgery is indicated when medical treatment fails and/or complication arises. There is no single ideal operation for chronic pancreatitis. More important is the selection of an appropriate method of management for a particular patient.

KEY WORDS

Pancreatitis, chronic pancreatitis, pseudocyst, alcohol, cysto gastrostomy, pancreatico jejunostomy, diabetes mellitus, secretin, exocrine, ultrasonogram