

EDITORIAL : VAN DIE REDAKSIE

PANCREATIC DISEASE

According to Bosdari¹ 'vine cuttings were first planted in the Cape in 1655, only 3 years after Van Riebeeck's landing. Four years later the first grapes were pressed, and a new branch of agriculture was founded'. The success of this enterprise has played a major part in the high incidence of alcoholic pancreatitis in the Cape and, indirectly, in the current interest of a group of Cape Town workers in pancreatic disease. Their experience, recorded in this issue of the *Journal*, provides a timely review of the subject and demonstrates clearly the importance of an aetiological approach to the disease, the diagnostic value of tests of pancreatic function, and the place of surgery in the treatment of pancreatitis.

Pancreatic disease may be regarded as the Cinderella of clinical gastroenterology. The relative inaccessibility of the pancreas to physical and radiological examination, coupled with the large functional reserve of the gland, causes difficulty in diagnosis; and failure to appreciate fully the clinical features of the many varieties of pancreatitis further contributes to its neglect. Until recently only 2 clinical varieties were widely recognized: acute pancreatitis — an abdominal emergency with emphasis on excruciatingly severe pain, and chronic pancreatitis — characterized by pain of varying severity associated with evidence of pancreatic insufficiency, viz. pancreatic calcification, diabetes, and steatorrhoea. Chronic relapsing pancreatitis, a third variety, was popularized by the Mayo group in 1946,² the predominant feature being a tendency to relapse with eventual destruction of the pancreas. Other types of pancreatitis have been described in the past decade, and it is now apparent that the term pancreatitis covers a spectrum of clinical syndromes ranging from the acute fulminating to painless varieties.

Advances in the understanding of pancreatitis have been limited by uncertainty regarding the aetiological roles of gallstones and alcohol in this condition. Early reports linked pancreatitis with inveterate alcoholics and, as recently as 1960,³ the impression remained that patients admitted to hospital with alcoholic pancreatitis were 'often in various stages of inebriation'. Again, the well-documented association between acute pancreatitis and a stone impacted in the lower end of the common bile duct⁴ or the ampulla of Vater⁵ tended to detract from the aetiological significance of cholelithiasis unassociated with demonstrable choledocholithiasis. The finding of dilatation, thickening, oedema, and even inflammation of the gallbladder in patients with chronic pancreatitis, led the Mayo workers⁶ to the view that disease of the biliary tract may be secondary to pancreatic disease, a view which detracted further from the aetiological significance of gallstones in pancreatitis. Small wonder that Cattell and Warren⁷ were hesitant about accepting gallstones as a cause of pancreatitis; gallstones, they pointed out, are found predominantly in elderly females whereas pancreatitis tends to occur in young adult males. The position was clarified by Howard and Ehrlich,⁸ who showed that gallstone and alcoholic pancreatitis were

different clinical entities each having a characteristic natural history and a predictable response to biliary surgery. This concept has been amply confirmed by the experience of the Cape Town team of workers.

Marks and Bank⁹ and Louw *et al.*⁹ considered alcohol the major aetiological factor in 148 of 243 patients with pancreatitis investigated during the relatively short period of 3 years. These patients usually presented with a history of acute, subacute or mild attacks of abdominal pain developing against a background of excessive alcohol intake of about 5-15 years' duration. The attacks themselves tended to start on the 'afternoon after the night before' and persisted for several days thereafter. The alcohol—pain time relationships provided a useful lead to the diagnosis, particularly in patients who were heavy social drinkers rather than confirmed alcoholics. About 95% of the 40 patients with calcific pancreatitis were attributed to alcohol, in keeping with the incidence reported from other high-alcohol intake areas such as Philadelphia¹⁰ and Marseilles.¹⁰ This contrasts with the nutritional basis of calcific pancreatitis found in certain underprivileged communities¹¹ and with the rarity of both alcoholic and calcific pancreatitis in Britain.¹² Calcific pancreatitis is frequently associated with diabetes and, to a lesser extent, steatorrhoea, but these symptoms may manifest many years after the cessation of painful attacks of alcoholic pancreatitis. Cirrhosis of the liver was only rarely encountered in patients with painful pancreatitis. On the other hand, a large proportion of patients with alcoholic cirrhosis were found to have *painless* pancreatitis. Complete alcohol withdrawal markedly reduced the liability to further attacks in patients with relapsing alcoholic pancreatitis. This, coupled with the failure of biliary or ablative surgery of the pancreas to prevent future attacks, unless followed by alcohol withdrawal, underlined the importance of establishing a positive diagnosis in patients with alcoholic pancreatitis. Louw *et al.*⁹ concede a limited place for surgery in alcoholic pancreatitis, mainly in patients suffering persistent pain despite complete alcohol withdrawal; these patients may have a pseudocyst of the pancreas, pancreatic duct obstruction, malignant disease or unrelated abdominal disease. Pancreatitis associated with biliary disease accounted for only 40 of the 243 patients. It included 16 cases of acute gallstone pancreatitis — a disease carrying a very much higher morbidity and mortality than alcoholic pancreatitis. Biliary surgery was mandatory in preventing subsequent and potentially lethal attacks of gallstone pancreatitis, a point which emphasized the importance of considering the possibility of gallstones in all patients with non-alcoholic pancreatitis, particularly in females and the elderly.

A clinically less important type of pancreatitis was the variety found on routine biochemical testing or at laparotomy in patients with gallstones; the pancreas in such patients usually showed the changes of chronic rather than acute pancreatitis. The survey thus demonstrated the im-

portance of an aetiological approach to alcoholic and gall-stone pancreatitis which together accounted for 77% of the total number of cases reviewed. In addition, Stein¹³ has drawn attention to the relatively high incidence of acute pancreatitis in children in Cape Town, and has shown that in the majority of his patients the condition arose on the basis of roundworm infestation.

The various tests employed in the diagnosis of pancreatic disease — in particular, the pancreatic-function test utilizing secretin and pancreozymin stimulation, has been discussed by Bank *et al.*,¹⁴ and the value and limitations of the tests assessed by Marks and Bank.⁸ The pancreatic-function test was found to be the most reliable of the tests employed. The glucose-tolerance test, though less specific, was shown to be of great diagnostic value, particularly in patients with disease confined largely to the body and tail of the pancreas in whom the other parameters of pancreatic function were sometimes normal.

The medical treatment of acute pancreatitis has always been directed against the prevention of further intra-abdominal damage rather than against the acute process itself. 'Trasyol', a potent antitrypsin and antikallikrein preparation, has been claimed to fill this need. Moshal *et al.*,¹⁵ in a controlled trial, confirmed the antitryptic action of the preparation and provided evidence to show that it reduces appreciably the duration of pain in an attack of alcoholic pancreatitis. These workers, however,

questioned the therapeutic effectiveness of the dosage recommended by the manufacturers and obtained more satisfactory results employing a greatly increased dosage scheme.

The papers published in this issue of the *Journal* shed new light on the difficult and rather neglected subject of pancreatic disease. The findings in the large series of patients investigated are an important contribution to our knowledge and go far towards the elucidation of many of the problems of aetiology, clinical presentation, diagnosis and treatment of pancreatitis. We consider this work to be of great practical importance and a salutary reminder of the burden imposed on the pancreas by the chronic intake of excessive amounts of alcohol — *plures crapula quam gladius*.

1. de Bosdari, C. (1955): *Wines of the Cape*, p. 17. Cape Town: Balkema.
2. Comfort, M. W., Gambill, E. E. and Baggenstoss, A. H. (1946): *Gastroenterology* 6, 239 and 376.
3. Howard, J. M. and Ehrlich, E. W. (1960): *Ann. Surg.*, 152, 135.
4. Opie, E. L. (1906): *Johns Hopk. Hosp. Bull.*, 12, 19.
5. *Ibid.* (1906): *Ibid.*, 12, 182.
6. Gambill, E. E., Comfort, M. W. and Baggenstoss, A. H. (1948): *Gastroenterology*, 11, 1.
7. Cattell, R. B., and Warren, K. W. (1953): *Surgery of the Pancreas*, p. 58. Philadelphia: Saunders.
8. Marks, I. N. and Bank, S. (1963): *S. Afr. Med. J.*, 37, 1039.
9. Louw, J. H., Marks, I. N. and Bank, S. (1963): *Ibid.*, 37, 1054.
10. Sarles, H., Muratore, R. and Sarles, J. C. (1961): *Hôp. Paris*, 25, 1507.
11. Zuidema, P. J. (1959): *Trop. Geogr. Med.*, 11, 79.
12. Howat, H. T. (1963): *Practitioner*, 191, 42.
13. Stein, D. (1963): *S. Afr. Med. J.*, 37, 1066.
14. Bank, S., Marks, I. N., Moshal, M. G., Efron, G. and Silber, R. (1963): *Ibid.*, 37, 1061.
15. Moshal, M. G., Marks, I. N., Bank, S. and Ford, D. A. (1963): *Ibid.*, 37, 1072.

DIE ETIEK

Dit is 'n kenmerk van die moderne tydperk om die empiriese vakwetenskappe na te streef; miskien is dit dus tydlig, op hierdie tydstip, om onself daaraan te herinner dat die geneesmiddels wat ons vandag kan voorskryf talle insluit wat sekerlik nie voldoen aan die doel waarvoor hulle beskikbaar gestel is nie. Ons was in die verlede en is nog steeds mede-skuldenaars aan die uitvoer van proewe op mense in die najaag van steeds groter en meer imponerende terapeutiese voordele, maar ten koste van min of meer belangrike foute en treurspelle. Dit bring die geneeskunde in onguns in die openbaar sowel as in die oë van elke pasiënt.

Daar is geen verposing in ons soektog na nuwe kennis in die geneeskunde nie; sonder twyfel sal dit altyd voortduur en stellig nog toeneem in tempo. Die onvermydelike versuim vandat 'n nuwe middel of tegniek ontdek word totdat dit in ons praktyk gebruik kan word, is verstaanbaar lank en strydig met ons welwillendheid. Tog is dit van die allergrootste belang dat alle nuwe middels vooraf deeglik in die laboratorium en in diere beproef moet word voordat dit in die kliniek beskikbaar gemaak word, beide wat betref die onmiddellike uitwerkings sowel as langdurige na- en newegevolge.

Is 'n praktisyn moreel geoorloof om 'n middel in sy praktyk toe te pas waarvan hy geen ondervinding het nie, terwyl hy boonop nie eers op hoogte is van die werklike geaardheid van die nuwe geneesmiddel nie? Ons kan geweldig veel verloor deur 'n onoordeelkundige en onnodige voorskryf; die gemeenskap sowel as die enkeling kan dit nog minder bekostig. Ons het inderdaad die toekomstige geslag in die holte van ons hande. Ons is persoonlik verantwoordelik aan ieder individuele pasiënt. Vandag meer as ooit tevore is daar die vereiste van meer en meer ver-

antwoordelikeheid. Geneeshere behoort selfs hulle pasiënte te beskerm teen wat in werklikheid neerkom op proefnemings op sigself. Geneeshere moet liever konserwatief die eg en ortodokse behandelings nastreef al het dit ook nie altyd die allerbeste en indrukwekkendste gevolge nie.

Elke pasiënt is 'n unieke fisiese en sielkundige organisme. In sy alledaagse omgang met die siekes is dit die dokter se plig om dit te onthou. Die toepassing van bepaalde nuwighede sonder inagneming van al die besondere omstandighede is geensins in die beste tradisie van die geneeskunde nie. Dit is maklik om aan voorbeelde te dink van nuwe geneesmiddels waarmee geweldige kwaad sowel as goed bereik kon word. Slegs met die volle medewete van die pasiënt en sy welwillende toestemming kan in sulke omstandighede die berekenbare risiko vir 'n bepaalde pasiënt met reg bereken en toegepas word.

Of die kwaad waarvan ons tyd swanger is slegs potensieel sal bly en of dit aktueel gaan word, hang af van die etiek van die geneeskunde en van die mate waartoe elke dokter bereid is om die gees en gesindheid van die volgende aanhaling uit een van die apokriewe boeke van die Ou Testament (*Eccl.* 38, 9 - 15) na te streef: 'Seun, wanneer jy siek word, moenie op jouself nalatig wees nie; . . . laat dit dan aan die geneesheer om sy werk te doen. Sy werk is 'n goddelike roeping, en jy het hom nodig; . . . Jy moet noodwendig soms tot die geneeshere jou toevlug neem; moet dit nie betwyfel dat hulle met die Here voorspraak sal maak nie, om 'n weg te vind waarlangs hulle jou verligting en genesing sal bring, deur jou dikwels te besoek . . .'¹

1. Versfeld, M. (1962): *Rondom die middeleeue*, p. 76. Kaapstad: Nasionale Boekhandel.