

# The Rationale for Programmed Abdominal Lavage in Acute Pancreatitis

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## ABSTRACT

Surgical lavage and necrosectomy used to be a standard treatment for both, sterile and infected necroses due to acute pancreatitis for decades. However, an early surgical lavage and necrosectomy in patients with sterile acute pancreatitis leads to the increased mortality and increased rate of perioperative complications. Since the surgical necrosectomy and lavage of the abdominal cavity in sterile necrosis following acute pancreatitis may lead to the infection, it is not advised as the treatment of choice. On the other hand, encouraging results were reported in patients with acute pancreatitis that were treated in conservative setting. There is also a promising attitude in the treatment of infected necrosis following acute pancreatitis using minimally invasive techniques such as endoscopic and percutaneous retroperitoneal drainage and lavage with satisfactory results. The rate in mortality and complications is lower than in patients treated with early surgical necrosectomy and lavage. However, surgical treatment is required in cases of infected necrosis where all other conservative and minimally invasive treatment patterns failed. It may be required even in cases of sterile necrosis

with the ongoing multiple organ failure. It is advised to postpone surgical intervention until the necrosis becomes walled-off if the patient's condition allows it. In cases of abdominal compartment syndrome, ongoing bleeding, bowel ischemia, and ongoing gastric outlet and bowel obstruction 4–8 weeks after acute pancreatitis onset, the surgical intervention is ultimate.

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