Dear Sir:

I read the paper by Hernández Garces et al. [1] with interest and I have some questions.

I have prospectively examined patency of the accessory pancreatic duct (APD) by dye-injection endoscopic retrograde pancreatography in 410 cases (291 controls, 46 acute pancreatitis, 32 chronic pancreatitis, 27 pancreaticobiliary maljunction, and 14 intraductal papillary mucinous tumor of the pancreas) [2, 3, 4]. Egress of dye from the minor duodenal papilla observed endoscopically was taken as an indication of APD patency. Patency of the APD in the control group was 43% (125/291). APD patency was correlated to the course and shape of the APD: patency in the long type (75%) was significantly greater than in the intermediate (38%), short (34%), or ansa types (15%) (P<0.01). The shape of the terminal portion was also correlated with patency of the APD: patency in the spindle type (93%) and cudgel type (88%) was significantly greater than in the branch type (7%) and saccular type (14%) (P<0.01).

Patency of the APD in patients with acute pancreatitis was 17% (8/46), significantly less than in the control group (P<0.01). I think that a patent APD may prevent acute pancreatitis by reducing pressure in the main pancreatic duct.

Patency of the APD in 32 patients with chronic pancreatitis was 32%. The APD was not detected in 6 cases and obliteration of the APD near the duodenum was seen in 4 cases. Cudgel appearance of the APD was detected in 8 cases, wherein the main pancreatic duct was also dilated. I think the appearance of the APD in patients with chronic pancreatitis is sometimes changed by acquired factors due to stagnation of pancreatic juice.

I wonder what the patency of APD is in patients with chronic pancreatitis in Hernández Garces series, and how many cases show no APD or halfway APD.

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Abbreviations APD: accessory pancreatic duct

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References
