Dear Sir,

I read with interest the beautifully written ‘How I Do It’ article by Dr. Richard Prinz entitled ‘Technique of Lateral Pancreaticojejunostomy’ in the June 1997 issue. While I agree with most all of his technical points, I notice in figure 3 that the Roux limb is brought through the right transverse mesocolon and oriented with the blind end towards the patient’s left (tail of pancreas). I orient my Roux limb differently, bringing it through the left mesocolon with the blind end of the Roux limb towards the head of the gland. While this is neither technically easier nor technically more difficult than the technique outlined by Dr. Prinz, it makes any type of reoperative surgery that might be necessary on the pancreas much easier. Usually when further surgery is needed in patients after a pancreaticojejunostomy, it is to remove or deal with the head of the pancreas. If the Roux limb is oriented as described by Dr. Prinz, the mesentery of the Roux limb will cover the superior mesenteric vessels, making it difficult to gain appropriate and safe exposure of the pancreas. If the Roux limb is oriented as I have described, exposure of the superior mesenteric vein is much easier.

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Reply

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Dr. Michael Sarr points out that experienced surgeons can modify the technique of pancreaticojejunostomy that I described in the June 1997 issue of Digestive Surgery and achieve good results. I start my anastomosis by bringing the Roux-en-Y limb of jejunum through an avascular area in the transverse mesocolon. This can be either to the right or the left of the middle colic vessels depending which provides the most direct access for the jejunum to the pancreas. More often it is in the right mesocolon. The place I have the most difficult time achieving exposure for the pancreaticojejunal anastomosis is the distal tail of the pancreas. I start my anastomosis with the blind limb of jejunum in that area since it allows placement of sutures under direct vision. As the anastomosis moves to the right the exposure improves and suture placement becomes technically easier. Dr. Sarr states that reoperative surgery is possibly easier with his method of placing the blind end to the head of the pancreas. I have had to reoperate on a small number of patients after pancreaticojejunostomy and I have reported 5 who had a revision of a side-to-side pancreaticojejunostomy because of undrained segments of pancreatic duct in the head of the gland. The Roux loop was taken off the head and the overlying pancreas excised to achieve better drainage. The same loop was used to complete the anastomosis in the redrained area. There might not have been enough jejunum to do this if the blind end had been placed in the head. I have done a small number of resections after failed pancreaticojejunostomy. Although these operations are obviously technically difficult, I have not found that placement of the Roux limb in the manner I have described increased that difficulty in any way. I appreciate Dr. Sarr’s thoughts on this matter and I am sure he will continue utilizing his technique with excellent results.