

Comment on “Immediate Oral Refeeding in Patients With Mild and Moderate Acute Pancreatitis: A Multicenter, Randomized Controlled Trial (PADI Trial)”

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We read with great interest the article by Ramírez-Maldonado et al,¹ which provides detailed insights into a matter of great interest to surgeons: the timing of oral refeeding in patients with mild and moderate acute pancreatitis (AP). To avoid abdominal pain and pancreatitis recurrence, many surgeons still adopt a conventional oral refeeding strategy, with guidelines lacking clarity on the timing of refeeding. This study provides high-level scientific evidence for the decision-making process in managing patients with mild and moderate AP.

This article was a high-quality multicenter randomized controlled study that compared the length of hospital stay and hospital costs between the immediate oral refeeding (IORF) group and conventional oral refeeding group. The results showed significantly shorter hospital stays, lower hospital costs, and milder complications in the IORF group. We would like to share some ideas and discuss some questions with the author.

The etiology of AP varies between countries and regions. Consequently, the treatment modalities differ. Biliary disease is the main cause of AP, accounting for 35% to 60% of cases in Western countries and also being a major cause in China.² In developed countries, AP is also associated with hyperlipidemia.³ In this study, most patients had acute biliary pancreatitis, followed by alcoholic pancreatitis. For patients with acute biliary pancreatitis, guidelines suggest that patients with concomitant obstruction and cholangitis should undergo endoscopic retrograde cholangiopancreatography (ERCP) within 24 hours of admission. Those with only ductal obstruction and no cholangitis are recommended to undergo ERCP within 72 hours of admission.^{4,5} We are interested in how many cases in this study were treated with ERCP? What are the refeeding strategies for such patients? Did the use of ERCP have any impact on the study? It remains unclear whether there were differences in the treatment modalities based on

etiology, which might also affect the length of hospital stay for patients.

Additionally, in clinical practice, some cases with mild or moderate AP may progress to severe AP, which requires timely identification and management.⁶ Patients in this study were randomized within 12 hours of admission. Fortunately, no patient from IORF Group and 6 patients from conventional oral refeeding group had progression of AP. Can we speculate that the early refeeding prevented the occurrence of progression or was it a coincidence? In addition, how did the clinicians persuade patients with abdominal pain and vomit (26/71) to start oral refeeding, and were additional pain assessments conducted before and after eating? Finally, we think that the treatment plans should not be popularized for all patients but should be tailored according to individual circumstances.

Finally, we congratulate the authors on completing a high-level prospective study. The study suggests that for patients with mild and moderate AP, the administration of an immediate oral low-fat solid diet is safe and feasible, which provides robust guidance for clinical practitioners.

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