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# Preface

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*Guest Editor*

The past decade has been noteworthy for incredible advances in the pathophysiology, diagnosis, and management of benign pancreatic disorders. The inflammatory cascade and genetics (or both) are now known to be intimately involved in the ravages associated with acute and chronic pancreatitis, respectively. Modern radiologic and endoscopic techniques allow precise imaging and physiologic assessment of pathologic pancreatic diseases. Tremendous advances in endoscopic and laparoscopic management of pancreatic disorders have simplified and hastened resolution and recovery of many benign conditions. Modern management of traumatic pancreatic injury has allowed improved diagnostic and therapeutic acumen in the operating room, which has translated to a decreased morbidity and mortality associated with this devastating injury. The role of islet cell transplantation to alleviate the complication of diabetes suffered by many patients who have benign pancreatic disorders has broadened, and progress in this field has been nothing less than spectacular. Finally, advances in the surgical management of benign pancreatic diseases have resulted in decreased procedure and pathologic-related complications and death.

To my knowledge, this is the first issue of the *Surgical Clinics of North America* devoted exclusively to benign pancreatic conditions—and rightly so. I can think of few areas in surgery where our decision-making and management have changed so rapidly in so short a period of time, and I offer a few examples. As Dr. David Sutherland pointed out to me when I asked him to contribute to this issue, the first islet cell transplant was reported in the *Surgical Clinics* in 1978. In 2007, this technique has reached the point

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where total pancreatectomy with auto islet cell transplantation can now safely be recommended to many with chronic pancreatitis as their *first* procedure. Necrotizing pancreatitis was almost a lethal event when I was in training, but refinements in diagnosis and operative management now mean that most will survive. Total parenteral nutrition previously utilized to "rest" the pancreas now largely plays a bridesmaid's role to enteral nutrition with its superior immune competence properties. In the past, Sphincter of Oddi dysfunction and pancreas divisum were diagnoses shrouded in mystery, but now both have defined diagnostic and therapeutic principles upon which to expect a satisfactory outcome. Modern nomenclature, diagnosis, and management of cystic neoplasms of the pancreas now allow superior nonoperative and operative outcomes.

I would like to sincerely thank all the contributors for their time and commitment to this endeavor. I value each as a surgical colleague, an expert in their respective field, and, after working with all, a friend. Their work and devotion on behalf of this issue I will not forget. I would like to specifically thank Ms. Catherine Bewick at Elsevier publications for her patience and expertise in helping this novice editor put this issue of the *Surgical Clinics of North America* together.

Finally, I was fortunate to be asked to take on the role of guest editor for this issue of the *Surgical Clinics of North America* by your regular consulting editor, Ronald F. Martin, MD. Ron has a wealth of experience in management of pancreatic diseases and truly should have edited this issue himself, except for the fact he was serving his *second* tour of duty in Iraq as an army reservist surgeon since the 2003 invasion. As a former military officer myself, I have a deep appreciation for this sacrifice and I know I speak on behalf of all the authors of this issue and the entire surgical community in thanking Ron for his commitment to our men and women in uniform and to our country.

Enjoy and savor this reading. It is my sincere hope that a future issue of the *Surgical Clinics of North America* on this very topic renders this issue a footnote to future advances.

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