A Whipple procedure, also known as a pancreaticoduodenectomy, is a complex abdominal operation used to treat both malignant and benign diseases of the head of the pancreas, lower part of the bile duct, and duodenum. Drs. Thompson and Christein have performed well over 1000 of these operations. Due to the complex nature of this procedure, it should only be performed by high volume surgeons at high volume centers, meaning those who perform 20 or more per year. Both Drs. Thompson and Christein are high-volume pancreatic surgeons working at Grandview Medical Center which qualifies as a high-volume pancreatic surgery hospital. Many studies have shown that when pancreatic operations are done by high-volume surgeons and at high-volume facilities, patients have better outcomes. Both Dr. Thompson and Dr. Christein usually have undergone specialty fellowship training in surgical oncology and hepatic, biliary, and pancreatic surgery (HPB), respectively.

The Whipple operation has been done routinely through an open incision but has also been done at some centers with highly specialized surgeons either laparoscopically or robotically. Both Drs. Thompson and Christein perform this operation through an open incision. During the Whipple operation, care is taken to examine the entire abdomen for spread of disease if malignancy is suspected. If metastatic disease is found, the operation is usually aborted due to the high risk nature as well as this finding of stage IV disease. Once metastatic disease is ruled out, the operation proceeds to ensure that the major blood vessels around the head of the pancreas are free from disease.

In order to remove the tumor or disease, the neck of the pancreas is divided, the gallbladder is removed if not already, and the stomach and first part of the intestine are divided. Some surgeons opt to preserve the entire stomach in the variation called a pylorus-preserving Whipple. Both Drs. Thompson and Christein usually remove part of the stomach during the operation. After the specimen has been removed, reconstruction consists of reattaching the small intestine to the divided neck of the pancreas, called a pancreaticojejunostomy, the top of the bile duct well above the tumor or blockage, called a hepaticojejunostomy, followed by the intestine to the stomach, called a gastrojejunostomy. These new connections, also called anastomoses, will allow the food that you eat to start the digestion process in the stomach and to continue in the intestine by mixing with bile and pancreatic juice containing enzymes. A stomach drainage or feeding tube may be left based on your nutritional status. Most surgeons will leave one or two operative drains, as do Drs. Thompson and Christein, around the pancreatic and biliary anastomoses if there is a leak. The rate of a bile leak is very low (<5%) while the overall rate of a pancreatic leak should be <20% overall with <5% being of significance. If there is a leak the patient will likely go home with a drain for a couple of weeks prior to removal in the office. The need for other drainage procedure or reoperations is unlikely but may need to occur under specific conditions.

During your hospital stay, most patients will spend a day or two in the intensive care unit to allow for closer monitoring. The overall length of hospital stay is usually about a week. During your hospital stay
your diet will slowly be advanced from ice and water, to other liquids, thicker liquids and then regular food. Your activity will also be increased starting the day of surgery and a physical therapist will be involved when necessary. When you go home you should have no restrictions on activity or diet. Although, after discharge to home, for the next 2 or 3 weeks you will feel fatigue and lack of appetite. These symptoms usually begin to improve after 3 or 4 weeks with a full recovery taking about 2 or 3 months. If the reason for your operation was malignancy, you will be seen by a medical oncologist within a month of your operation.