

# Preventive pancreatic stents in the management of acute biliary pancreatitis

<b>Submission date</b> 13/11/2014	<b>Recruitment status</b> Suspended	<input checked="" type="checkbox"/> Prospectively registered <input checked="" type="checkbox"/> Protocol
<b>Registration date</b> 09/12/2014	<b>Overall study status</b> Completed	<input type="checkbox"/> Statistical analysis plan <input type="checkbox"/> Results
<b>Last Edited</b> 04/05/2020	<b>Condition category</b> Digestive System	<input type="checkbox"/> Individual participant data <input type="checkbox"/> Record updated in last year

## Plain English summary of protocol

### Background and study aims

Acute inflammation of the pancreas (acute pancreatitis) can be a severe or even life-threatening disease. Gallstones are the most common cause, which is called acute biliary pancreatitis (ABP). If you have co-existing infection and inflammation of the biliary tree (acute cholangitis) and/or persistent biliary obstruction (cholestasis), an endoscopic procedure (called ERCP) is beneficial which includes clearance of the biliary tree. Severe complications occur in 10-20% of all cases despite endoscopic treatment, probably because the opening of the pancreatic duct is simultaneously obstructed. Theoretically when we temporarily place a small plastic tube (a preventive pancreatic stent or PPS) into the pancreatic duct, it keeps it open until the inflammation resolves and the risk of pancreatic duct obstruction diminishes. Our goal is to show the positive effect of PPS placement added to the standard endoscopic therapy. The study findings should help to optimize the treatment of this severe disease.

### Who can participate?

Patients aged 18 or over with cholangitis and/or cholestasis.

### What does the study involve?

Participants will be randomly allocated to receive either the standard endoscopic treatment or PPS placement added to the standard treatment. Every patient will be hospitalized and receive similar medical treatment. Clinical and laboratory data will be collected for outcome measures.

### What are the possible benefits and risks of participating?

Patients who receive PPSs may have better overall outcome and quicker symptom resolution compared to the standard treatment. The main risk of placing a PPS is unsuccessful placement which might cause an even worse outcome; therefore only very experienced endoscopists are involved in this study.

### Where is the study run from?

The PREPAST study is set up by the Hungarian Pancreatic Study Group in Szeged, Hungary. All procedures will be performed at the participating medical centers.

When is the study starting and how long is expected to run for?

It is anticipated that recruitment will start in early 2015. Based on our preliminary calculations the total target number of participants will be enrolled over a 4-year period; however, if more centers join in the study it will be shorter.

Who is funding the study?

The Hungarian Pancreatic Study Group (HPSG).

Who is the main contact?

Zsolt Dubravcsik MD

dubravcsikzs@gmail.com

Professor Péter Hegyi MD, PhD,

hegyi2009@gmail.com

## Contact information

### Type(s)

Scientific

### Contact name

Dr Zsolt Dubravcsik

### Contact details

Nyíri út 38

Kecskemet

Hungary

6000

+36 (0) 30 9599257

dubravcsikzs@gmail.com

### Type(s)

Scientific

### Contact name

Dr Peter Hegyi

### Contact details

University of Szeged

Dugonics Ter 13

Szeged

Hungary

6720

+36 (0)70 3751031

hegyi2009@gmail.com

## Additional identifiers

### Protocol serial number

PREPAST

# Study information

## Scientific Title

Preventive pancreatic stents in the management of acute biliary pancreatitis: PREPAST, a prospective multicenter randomized controlled trial (Hungarian Pancreatic Study Group)

## Acronym

PREPAST

## Study objectives

We hypothesise that placement of a preventive pancreatic stent (PPS) at the course of early endoscopic retrograde cholangiopancreatography (ERCP), endoscopic sphincterotomy (ES) and stone extraction reduces morbidity and mortality in acute biliary pancreatitis (ABP) patients with cholangitis and/or cholestasis compared to the standard of care ERCP, ES and stone extraction.

## Ethics approval required

Old ethics approval format

## Ethics approval(s)

National Medical Ethics Committee, Hungary, 13/10/2014, ref.: ETT TUKEB 030174/2014/OTIG

## Study design

Prospective randomized controlled multicenter trial

## Primary study design

Interventional

## Study type(s)

Treatment

## Health condition(s) or problem(s) studied

Acute biliary pancreatitis (ABP)

## Interventions

Patients with ABP and co-existing acute cholangitis will receive early endoscopic intervention (group A). Patients in group A will be randomized either into group A1 (ERCP, ES treatment) or into group A2 (ERCP, ES + PPS treatment). Patients with ABP but without evidence of acute cholangitis will be assessed for evidence of cholestasis. Patients without co-existing acute cholangitis but evidence of cholestasis will be randomized to receive conservative treatment or early ERCP, ES and bile duct clearance or early ERCP, ES, bile duct clearance plus PPS insertion (group B). Patients receiving conservative treatment will be assessed at 24 hours after randomization (no later than 72 hours from the onset of pain) for clinical and laboratory signs of persistent cholestasis. If this is present patients will receive ERCP, ES and bile duct clearance and their data will be collected separately. Patients in group B will be randomized either into group B0 (conservative treatment), into group B1 (ERCP, ES treatment) or into group B2 (ERCP, ES + PPS treatment). Patients without signs of cholestasis (and acute cholangitis) will receive conservative treatment (group C), and will not be randomized.

## Intervention Type

Procedure/Surgery

## **Primary outcome(s)**

Composite of mortality and major morbidity (described as a complicated course of ABP). A complicated course is described as any of the following three:

1. Moderate and severe acute pancreatitis (including temporary and persistent organ failure)
2. Any complications including systemic (exacerbation of pre-existing co-morbidity) and all local complications (acute peripancreatic fluid collection without tendency of spontaneous resolution, pancreatic pseudocyst, acute necrotic collection, walled-off necrosis) of AP as described in the revised Atlanta classification
3. Mortality

## **Key secondary outcome(s)**

Secondary endpoints related to ABP outcome:

1. Multi-organ failure in each subgroup
2. Mortality rate in each subgroup
3. Pain score on admission, 24 and 72 hours after ERCP (or after randomization in group B1 conservative treatment group)
4. New onset of sepsis
5. The proportion of patients with severe course of ABP
6. The proportion of patients with severe organ failure requiring respiratory support (mechanical ventilation) and/or cardiac support (vasopressors) and/or renal support (haemodialysis)

Secondary endpoints related to endoscopic treatment:

1. PPS insertion success rate
2. Consequences of attempted but failed pancreatic stenting (this subgroup will be analyzed separately)
3. Endoscopists experience on PPS success rate and ABP outcome
4. The influence of the endoscopic technique used on the outcome of ABP
5. Influence of patient and procedure related risk factors of post-ERCP pancreatitis (published by the European Society of Gastrointestinal Endoscopy ESGE) on the outcome of ABP patients who underwent ERCP and on the success rate of PPS insertion

## **Completion date**

31/08/2022

## **Eligibility**

### **Key inclusion criteria**

1. Age  $\geq$  18 years (either sex)
2. Diagnosis of acute biliary pancreatitis
3. Written informed consent
4. Possibility of performing ERCP within 48 hours calculated from the onset of pain

### **Participant type(s)**

Patient

### **Healthy volunteers allowed**

No

### **Age group**

Adult

**Lower age limit**

18 years

**Sex**

All

**Key exclusion criteria**

1. Pregnancy
2. Acute pancreatitis due to alcohol, hyperlipidaemia, malignancy or post-ERCP pancreatitis
3. Pain onset >48 hours
4. Absence of abdominal pain (the onset cannot be assessed)
5. Liver cirrhosis Child score C
6. Pancreatic fluid collections or necrosis on initial imaging at presentation
7. INR>1.6 and uncorrectable by the time of ERCP
8. Previous endoscopic sphincterotomy

**Date of first enrolment**

01/01/2015

**Date of final enrolment**

31/12/2021

**Locations****Countries of recruitment**

Hungary

**Study participating centre****University of Szeged**

1st Department of Internal Medicine

Dugonics Ter 13

Szeged

Hungary

6720

**Study participating centre****County Hospital**

Department of Gastroenterology

Nyiri ut 38.

Kecskemet

Hungary

6000

**Study participating centre**

**University of Pecs**

1st. Department of Internal Medicine  
Ifjusag ut 13.  
Pecs  
Hungary  
7624

**Study participating centre****National Health Center**

Department of Gastroenterology  
Podmaniczky u. 111.  
Budapest  
Hungary  
1062

**Sponsor information****Organisation**

Hungarian Pancreatic Study Group (HPSG) (Hungary)

**Funder(s)****Funder type**

Research organisation

**Funder Name**

Hungarian Pancreatic Study Group (HPSG) (Hungary)

**Funder Name**

European Social Fund

**Alternative Name(s)**

European Social Fund, Европейският социален фонд, Европейският социален фонд плюс, Fondo Social Europeo, Fondo Social Europeo Plus, Ευρωπαϊκό Κοινωνικό Ταμείο, Ευρωπαϊκό Κοινωνικό Ταμείο+, Ciste Sóisialta na hEorpa Plus, Ciste Sóisialta na hEorpa, ESF, ESF+, ЕСФ, ЕСФ+, FSE, FSE+, EKT, EKT+, CSE, CSE+

**Funding Body Type**

Government organisation

## Funding Body Subtype

National government

## Location

## Funder Name

European Union

# Results and Publications

## Individual participant data (IPD) sharing plan

### IPD sharing plan summary

Other

### Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Protocol article</a>	protocol	01/03/2015		Yes	No