

**Planned Repeated Necrosectomy***Gregory G. Tsiotos, Michael G. Sarr***STEP 1**

The operation begins with a systematic, comprehensive, manual and visual exploration of the entire pancreas as well as an exploration to delineate the extent of necrosis in both paracolic gutters, the root of the small bowel mesentery below the transverse mesocolon, and the suprapancreatic retroperitoneal tissues. CT is the guide to locating all areas of necrosis.

Entrance into the lesser omental sac is through the gastrocolic ligament (as opposed to through the transverse mesocolon), as this approach provides superior access to the pancreatic bed not hindered by risking injury to the middle colic or right colic vessels. Although necrosis often presents through the left mesocolon when the pancreatic body and tail are involved or through the right mesocolon when the head and uncinata are involved, any approach from below the mesocolon for a complete pancreatic necrosectomy offers suboptimal exposure and risks inadvertent surgical trauma and incomplete necrosectomy. We believe that exposure via the gastrocolic ligament is especially important for necrosis of the body and tail, except when the necrotizing process involves predominantly the head and uncinata process of the pancreas or when previous pancreatic surgery has obliterated the lesser sac.

Probing the gastrocolic ligament bluntly with a finger will usually identify the cavity containing the necrosis in the lesser sac. Once the finger finds the cavity, the space is unroofed in a controlled fashion, with care to protect the gastroepiploic arcade and vessels in the transverse mesocolon.

