

'Do Not Put Off the Writing ... Unpublished Work Effectively Does Not Exist!'

An Interview with Clem W. Imrie, Emeritus Professor of Surgery,
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Abstract

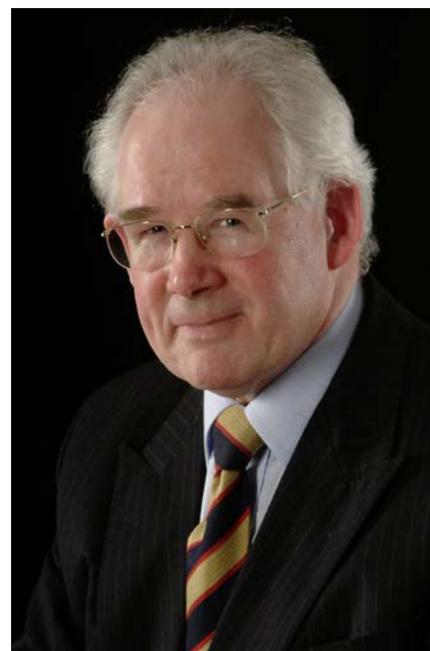
In this interview, Professor Clem W. Imrie shares with *Pancreatology* his life experience as a surgeon and scientist in pancreatic research. He is a world-recognized pancreatologist for his contribution to the understanding of pancreatic diseases; his work on the characterization of pathogenesis as well as the treatment of pancreatitis has been seminal.

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M.E.F.-Z.: What initiated you to work in pancreas research in the first place?

C.W.I.: While in my first year of clinical surgical training, two senior surgeons at Glasgow Royal Infirmary, without discussing together (and only four days apart), each individually remarked to me on the high frequency of emergency admissions of patients with acute pancreatitis. C.J. Longland and Kennedy Watt both pointed me towards tabulation and study of these patients.

After a 10-year retrospective study of 140 patients, I commenced a prospective single-hospital, 4-year documentation of the natural history of acute pancreatitis (AP) in over 200 patients. This then led to a single-centre, double-blind, randomized study of aprotinin (Trasylol) therapy in a further 160 consecutive patients.



Emeritus Professor Clem W. Imrie

M.E.F.-Z.: You have pioneered pancreas research in so many directions. At the end of the day, what has given you the most personal satisfaction?

C.W.I.: The greatest satisfaction has been the completion – with the invaluable help of a large team of many clinical colleagues as well as biochemists, haematologists, pathologists and imaging specialists – of 9 double-blind or randomized clinical studies of the management of AP. During these studies a practical UK and European scoring system for disease severity was described after cooperation with John Ranson and the biochemists of New York University. This led to great emphasis in the late 1970s on the importance of hypoxaemia in determining outcome. Eventually working together with Colin McKay in the 1990s, we moved on to organ failure scores as a better way of grading the risk of death and major complications in severe AP. Along the way of these clinical studies I consider the identification of the role of low blood albumin in hypocalcaemia; that pregnancy-associated AP is invariably a variant of gallstone AP, that hyperlipaemia in AP is usually alcohol induced were useful contributions from our Glasgow team. The ingenuity and surgical dexterity of Ross Carter were vital in the origin of minimally invasive surgery as a therapy for infected pancreatic necrosis. All of these aspects have given encouragement, while the failure of identification of a specific therapy for severe AP has been disappointing.

M.E.F.-Z.: Based on your experience as mentee and mentor, can you comment on the value of mentorship for the development of new investigators?

C.W.I.: The value of effective mentorship is often underestimated. I was stimulated by my two original mentors followed in 1972 by Sir Rodney Smith of St. George's Hospital London before a major 7-year mentoring by Leslie Blumgart back in Glasgow. He was a great encourager at a crucial stage by driving and directing the necessary paper-writing and presentations. His high-speed return of draft papers fully annotated meant that the fires of enthusiasm for the current project received oxygen.

In my role as a mentor it has been important to keep new clinical investigators aware that the patients are themselves our teachers. While technology advances we must observe, listen to them and accurately document events. Discussion and interchange of ideas should be

as natural as breathing. Young and older investigators should be wise listeners as well as enjoying the freedom to voice their own ideas. It is good for young investigators to attend local, national and international meetings to supplement their knowledge and to have their aspirations channelled and their minds challenged.

M.E.F.-Z.: What is your advice to the young investigators who are beginning in the field of pancreas research?

C.W.I.: Plan the investigation and studies with great care. Once started, have the commitment to completion of the project as soon as possible. Do not put off the writing of the report and do not dither about journal submission. Unpublished work effectively does not exist!

M.E.F.-Z.: What do you think are the big questions that need to be answered in pancreatology?

C.W.I.: The big unanswered questions in pancreatology depend on your personal clinical or laboratory perspectives. We now know a great deal of putative therapies for severe AP do not help, but still await a specific treatment. The current focus on supportive intensive care for those with the most severe AP early in the disease is all we currently can honestly offer. Minimally invasive therapy of infected pancreatic necrosis as a later complication has been supported by the recent Dutch National Study. In chronic pancreatitis we require large prospective multinational studies to accurately define disease incidence and the relative importance of alcohol and tobacco exposure in aetiology, while larger prospective randomized studies of different therapies are needed. Earlier accurate diagnosis of pancreatic cancer is a great need. The link between systemic inflammatory response and poor outcome in carcinoma of pancreas warrants study as surgical and non-surgical therapies appear much less effective in those with such a response observed at disease presentation.

M.E.F.-Z.: What do you think is the major need that a journal like *Pancreatology* should fill?

C.W.I.: The major need for *Pancreatology* is to move forward on the foundations already laid by previous contributors and editors by incorporating high-quality original work as well as reviews. More encouragement for greater numbers of Asian papers would move us towards an even more valuable international journal.