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# Nádory podjaterní oblasti

# Diagnostika a léčba



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### Pancreas

#### □ Lymphadenectomy

What is the role of lymphadenectomy in pancreatic cancer surgery?

Stage-based survival prediction of pancreatic cancer is strongly influenced by total LN counts and numbers of negative LNs obtained. Although the mechanism remains unclear and could reflect confounding factors (margin status and institutional volume), an attempt to resect and examine at least 15 LNs to yield preferably between 10 and 15 negative LNs seems sensible for curative-intent pancreatectomy.

Although a much larger study would have more power, the studies we can find in the present literature, show both the decrement in quality of life and no survival difference in the groups with extended lymphadenectomy and make this procedure unattractive for further prospective investigation.

On the contrary, distal pancreatectomy with extended lymphadenectomy for the treatment of invasive pancreatic carcinoma of the body and tail contributed to long-term survival in selected patients without mortality. Effective postoperative treatment should be evaluated in patients with positive lymph nodes and/or the presence of histologic vein invasion even after a curative resection, because long-term survival cannot be expected.

# □ Preoperative biliary drainage

In patients without cholangoitis bile duct drainage is not generally recommended According to your experience, what is the role of preoperative bile duct decompression? Do you consider any bilirubinaemia as reason for preoperative bile duct drainage? When yes, do you prefer endoscopic or percutaneous approach?

In case of cholangitis or liver failure, I employ the following guideline: preoperative biliary decompression to reduce the serum bilirubin concentration below 2 mg/dl and to control segmental cholangitis. The absence of hepatic failure, the most frequent cause of postoperative in-hospital death, is probably attributable to reduced jaundice, recovery of damaged liver function, and early treatment of segmental cholangitis by suitable biliary decompression. I prefer, whenever is possible, the endoscopic approach.

# □ Tissue glue in prevention of PJA leak

Some Italian centers report remarkable results of pancreatic resections in patients at risk (tender gland, narrow main pancreatic duct etc.) applying new generation of glues for scaling the main pancreatic duct. Have you personally any experience with this technique? If not, do you regard this technique to be interesting?

I generally use cyanoacrylate (Glubran 2) for occlusion of main pancreatic duct when its caliber is less then 3 mm diameter and pancreatic remnant is soft. Although occlusion of the pancreatic duct did not reduce postoperative intra-abdominal complications, it appears to be a valid option for treating patients with a soft pancreas and narrow Wirsung duct, which are associated with a high risk of pancreaticojejunal anastomotic fistula. A fistula developing after duct occlusion is easier to manage and

329

# Nádory podjaterní oblasti

is associated with lower postoperative mortality. Cyanoacrylate used for management of the pancreatic stump is as safe and effective as other, similar glues. In this way I treated 28 patients. A pancreatic fistula developed in 6 patients (23%). The fistula closed within 1–8 months of surgery. Overall mortality was 3,5% (one patient died of hemorrhage due to acute necrotizing hemorrhaging pancreatitis after 3 months). Two patients were lost to follow-up (range: 5–43 months). Of the remaining 26 patients, 21 (80,7%) regained their normal weight within 12 months of surgery and 8 (30,8%) developed diabetes mellitus. Ten patients died due to disease progression and 16 are currently alive.

# □ Anastomosis

12

There is no clinical randomized trial documenting superiority of any surgical anastomotic technique for GIT-pancreatic anastomosis. As well as it is not documented, what type of GIT continuity reconstruction is the best. Neither, if it is necessary to put stent into the main pancreatic duct and what type. Nevertheless we would like to ask you what is your experience and what type of anastomosis and reconstruction do you prefer?

I usually perform a termino-lateral (TL) double-layer pancreato-jejunostomy. In case of large caliber (greater then 3–4 mm diameter) main pancreatic duct I perform a duct-mucosal anastomosis with interrupted 5/0 suture. I put the stent into the Wirsung duct and I remove it after anastomosis is completed. Gastrointestinal reconstruction is made by a pylorus-preserving anastomosis according to Traverso-Longmire procedure.

## □ Vessels resection

The crucial point of pancreatic resections is the dissection round the upper mesenteric vessels, even if they aren't infiltrated by tumor. How do you reach R0 resection in this critical area?

In this area R0 resection can be achieved, if necessary, by segmental resection of involved vessels.

Is there any rational to extant the operation to segmental resection of large vessels (superior mesenteric vein etc.)? If you perform these radical operations, which type of vessel reconstruction do you use?

Resection of the superior mesenteric-portal vein (SMPV) during pancreatoduodenectomy is disputed. Although the morbidity and mortality of patients after this operation are acceptable, survival is limited. If selected carefully, pancreatectomy combined with SMPV resection can be performed safely, without increase in the morbidity and mortality. SMPV resection should be performed only when a margin-negative resection is expected to be achieved. SMPV invasion is not associated with histologic parameters suggesting a poor prognosis. I generally prefer a reconstruction obtained by a PTFE (goretex) graft.

### □ Staging

Do you use peroperative ultrasonography to assess tumor relationship to the vessels?

In our Center we generally can achieve every information we need about large vessels involvment by preoperative multislice-angio-TC and endoultrasnography examination.

How do you detect small lesions e. g. functional neuroendocrine tumors?

In this kind of lesions intraoperative ultrasonography can be very useful, indeed. *Where, do you thing, is the place of laparoscopy in pancreatic oncologic surgery?* 

Nowadays, in the 21st century, I think that every surgeon have to look at laparoscopic pancreatic surgery for cancer like a way feasible to run. But I think that we need more and more studies able to confirm the same results in survival, morbidity and mortality of traditional pancreatic surgery. At the state of the art, I think that laparoscopic surgery can be very useful in peroperative staging of disease and in performing biopsies of involved tissues.

# □ Radiofrequency ablation

*Is there any role (except hepatic metastases) of RFA in pancreatic cancer treatment? Have you any experience with this method?* 

There is little reported experience of radiofrequency ablation of pancreatic tumors. More experience is required to assess the spectrum of complications and if there is true oncological efficacy. Further studies are required to detect whether this technique can improve survival/quality of life alone or in combination with other therapies. I have no experience in this method.

# □ Robotic surgery

What is the importance of robotic surgery in this area?

At present days, I think that is the same about laparoscopic surgery. I conclude that robotic surgery has now moved beyond the learning phase.

# Biliary tree

Have you any experience with photodynamic therapy of nonresectable biliary tree tumors?

Photodynamic therapy has demonstrated promise in the palliative treatment of advanced cholangiocarcinoma and in prolonging survival in patients with this kind of disease. Additional randomized clinical trials are needed to fully evaluate both the optimum frequency and treatment interval of endoscopic PDT in the management of advanced cholangiocarcinoma. I have no experience in this method.

Staging and assessment of resectability of biliary tree tumors is very difficult. Which staging system do you use and which imaging methods do you rely on?

Multislice-angio-Tc, cholangio-RM and endoultrasonography examination give us all information we need for staging and assessment of resectability.

Do you thing that there is any benefit of direct cholangiography, when the drainage of bile duct is not needed?

Three-dimensional direct multi-detector row CT cholangiography is accurate and feasible for defining the extent of ductal invasion by hilar cholangiocarcinoma, especially in patients with preliminary biliary drainage.

Do you always strive to gain preoperative biopsy?

Every time is possible.

What is you strategy when histological preoperative finding is not predicative and there is theoretical indication of extensive surgical procedure?

Today, a lot of patients may be candidates for extensive curable or palliative surgery because of rapid advances in surgical technique and diagnostic imaging. Approximately 40 % of patients with hilar cholangiocarcinoma may undergo surgical

# Nádory podjaterní oblasti

resection with a curative intent, which has increased overall 5-year survival rates to 20 %. Consequently, defining the extent of biliary ductal invasion and constructing the exact road map of the biliary tree in such patients are crucial for planning and choosing the appropriate treatment and are directly connected with the prognosis. So, I think that the surgeon must give a surgical chance to every patient who is able to safely tolerate an intervention. As well, we must remember that intraoperative histological examination can help the surgeon.

*Do you have personal experience with overtreatment in course of false positive diagnosis?* 

Fortunately, the rate of false positive diagnosis in our center is very poor. Radiologists, pathologists and clinicians work all together to reduce it.

# ■ Gallbladder

Despite of the progress in hepatic surgery we didn't achieve significant improvement of survival rate or survival time at patients with T3, T4 gallbladder tumors neither in the cases with intact biliary tree. What is your strategy and which type of resection do you prefer at these advanced tumors? What's your median survival in your center?

I usually perform en bloc cholecystectomy plus segmental hepatic resection of V and IV b plus lymphadenectomy on stations No<sup>o</sup> 5-8-9-12-13 according to the Japaneese classification.

