# Ca Pancreas : Cosa aggiunge l'endoscopia

- ERCP utile per:
  - La ricerca di piccoli tumori non visibili alla CT ( stenosi irregolare del dotto bil >1cm , brusca interruzione del dotto pancreatico, segno del doppio dotto)
  - Palliare l'ostruzione biliare drenando il dotto
  - brush cytology del dotto pancreatico che una bassa sesnsibilita' ma altissima specificita'
- EUS :
  - Importante aiuto nella diagnosi e caratterizzazione della lesione pancreatica
  - Ottenere una citologia/ biopsia tissutale

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# Il Drenaggio biliare preoperatorio nelle stenosi coledociche da neoplasia pancreatica

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# Background

- L’ittero e’ associato ad alta mortalita’ preoperatoria
- Il drenaggio preoperatorio puo’ invertire le alterazioni fisiopatologiche ( la sintesi epatica, le funzioni di clearance, le funzioni di barriera della mucosa intestinale)

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# Malignant biliary obstruction: preoperative drainage

## Cochrane Database Systematic Review

- 4 RCT`s on PTCD, 1 RCT on endoscopic drainage
- 320 patients
- Drainage vs no drainage:
  - No difference in mortality
  - Higher morbidity (endoscopy study)
  - Longer hospitalisation
  - Increased costs
- However: poor quality of the included trials

Wang Q, Cochrane Database Syst Rev 2008; 16(3): CD005444

# RCT in patients with pancreatic head cancer

Van der Gaag NA, NEJM 2010; 362:129-37

## Limiti

- Esclusione dei pazienti con bilirubina > di 14 mg/dl
- Eccessivamente alto livello di insuccessi endoscopici (25%)
- Eccessiva frequenza di cambio precoce di stent (30%)
- Eccessiva-frequenza di colangiti secondarie
- Eccessiva frequenza di complicanze correlate-
- Elevato n. di lesioni benigne o non resecabili(39 %)

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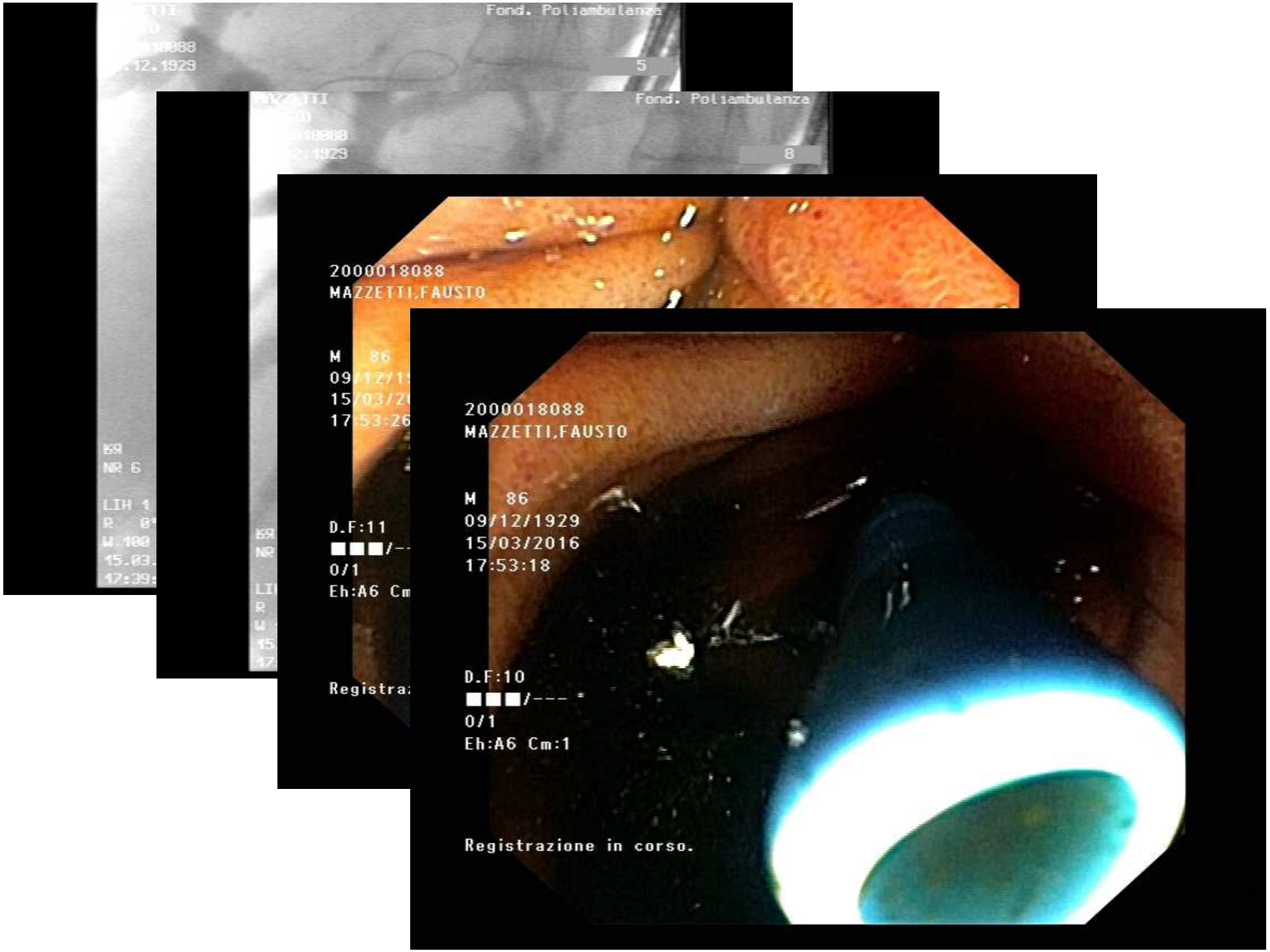
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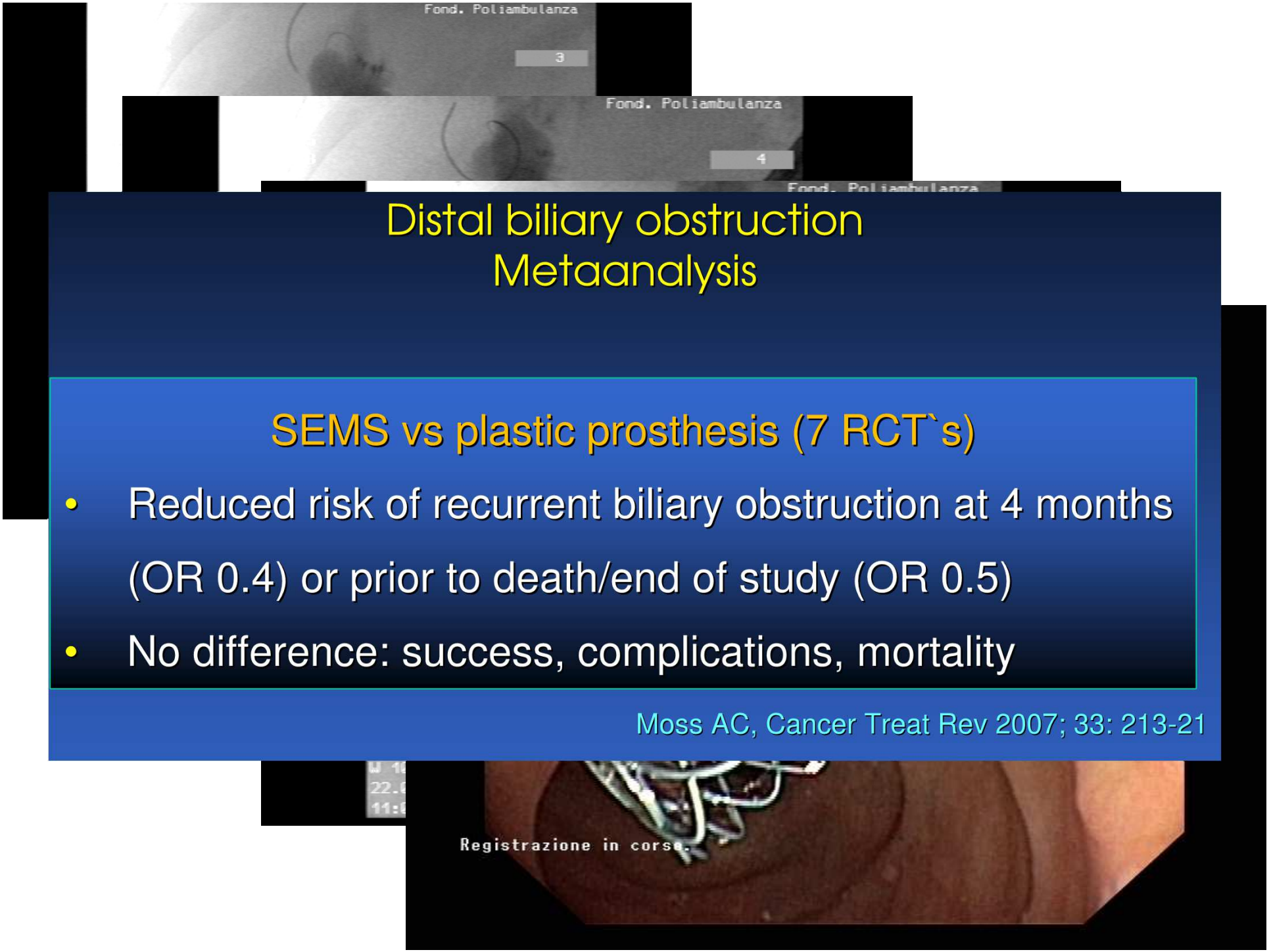
# Distal biliary obstruction
# Metaanalysis

## SEMS vs plastic prosthesis (7 RCT`s)

- Reduced risk of recurrent biliary obstruction at 4 months (OR 0.4) or prior to death/end of study (OR 0.5)
- No difference: success, complications, mortality

Moss AC, Cancer Treat Rev 2007; 33: 213-21

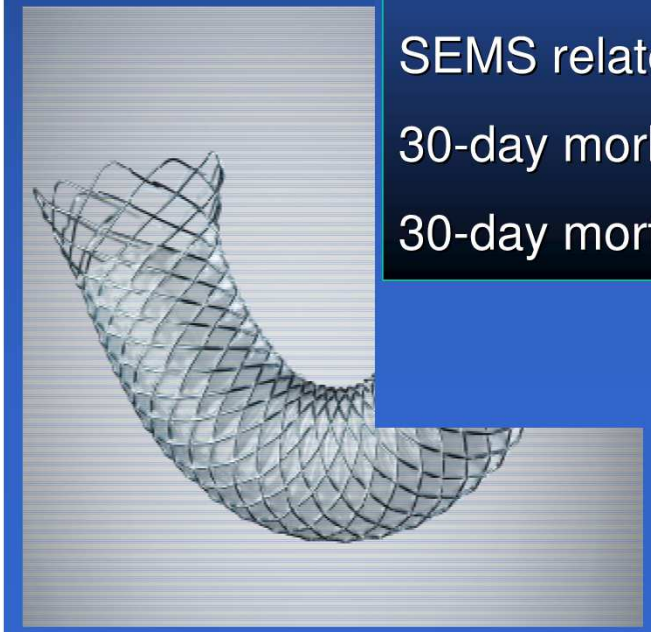


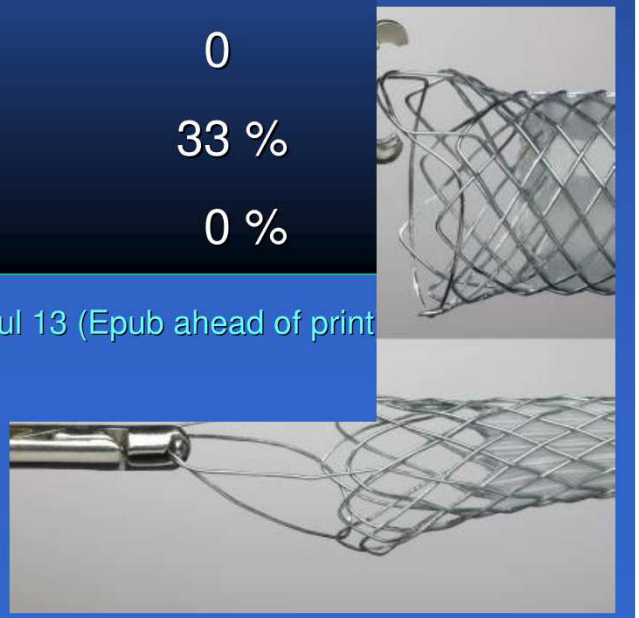
# Malignant biliary obstruction: preoperative drainage

## Partially covered SEMS as a bridge to surgery

| | |
|---|---|
| Patients | 79 |
| Previous plastic stents | 70 % |
| Neoadjuvant RCTx | 95 % |
| Median time between stenting and surgery | 120 days |
| SEMS related difficulties during PD | 0 |
| 30-day morbidity rate | 33 % |
| 30-day mortality rate | 0 % |

Singal AK; Dig Dis Sci 2011; Jul 13 (Epub ahead of print





# Indicazioni al drenaggio preoperatorio

Obbligatorie

- Chirurgia non immediata
- RCTx/CTx neoadiuvante
- Colangite
- Livello di bilirubina > 14mg/dl

Stent metallici autoespandibili

Permettono di posporre l'intervento chirurgico

Riducono il rischio di colangite

Non creano problemi chirurgici per la Duodeno-cefalo

Sono un adeguato drenaggio biliare in caso di non resecabilita'

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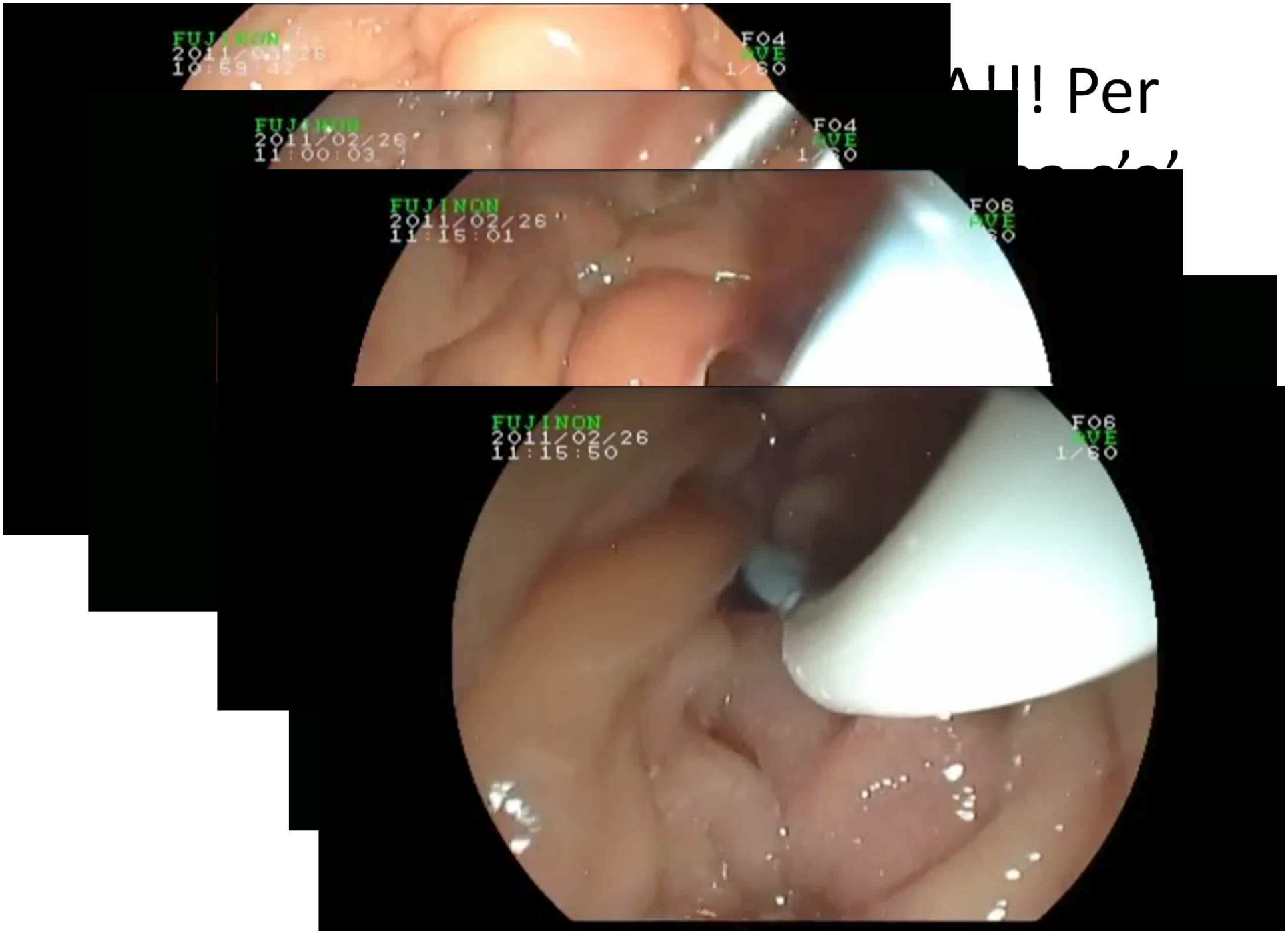
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# L’approccio polispecialistico

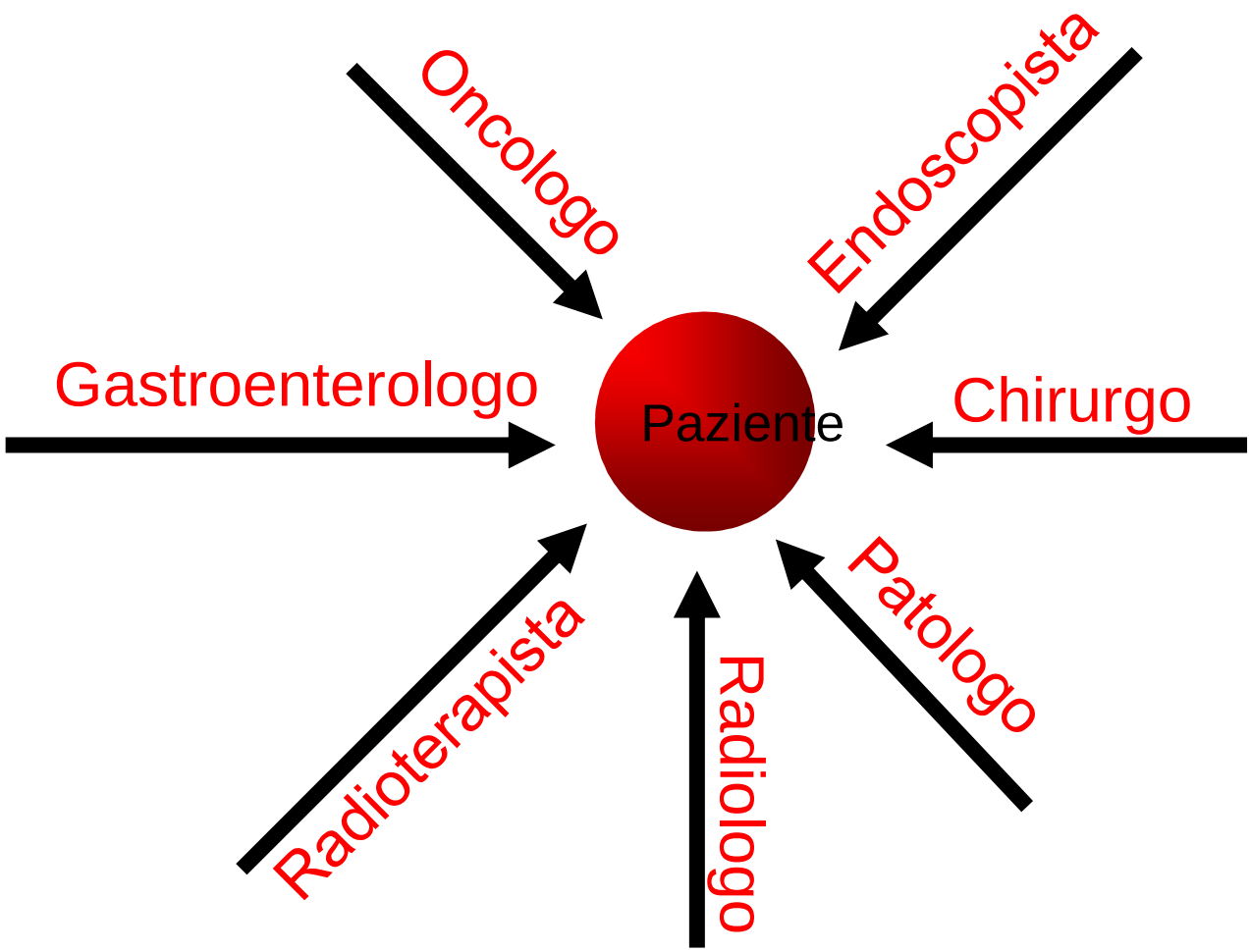

**Table 1 – Additional data extracted from randomized controlled trials included in the Cochrane Review [8].**

| Study | PBD | | | | Direct surgery | |
|---|---|---|---|---|---|---|
| | Total number of patients | Number with minor complications related to PBD | Number with serious complications related to PBD | Complications of surgery (after PBD) | Total number of patients | Complications of surgery |
| Hatfield *et al.* [13] | 29 | NA | 4 | 4 | 28 | 4 |
| Lai *et al.* [14] | 43 | NA | 12 | 16 | 44 | 18 |
| McPherson *et al.* [15] | 34 | NA | 8 | 9 | 31 | 13 |
| Pitt *et al.* [16] | 37 | NA | 4 | 16 | 38 | 20 |
| van der Gaag *et al.* [17] | 102 | 20 | 27 | 48 | 94 | 35 |
| Wig *et al.* [18] | 20 | 2 | 4 | 5 | 20 | 11 |
| Total | 265 | 22 | 59 | 98 | 255 | 101 |

NA = data not available.

**Table 3 – Base case results.**

| | PBD | | Direct surgery | |
|---|---|---|---|---|
| Costs | | | | |
| UK£ | 10,775 | (10,502 to 11,048) | 8221 | (7954 to 8487) |
| US$ | 15,616 | (15,220 to 16,012) | 11,914 | (11,528 to 12, 300) |
| QALYs | 0.337 | (0.337 to 0.338) | 0.343 | (0.343 to 0.344) |
| MNB | | | | |
| UK£20,000 | −4031 | (−3758 to −4304) | −1359 | (−1092 to −1626) |
| US$28 986 | −5843 | (−6485 to −5685) | −1969 | (−2551 to −1768) |
| UK£30,000 | −659 | (−386 to −933) | 2072 | (1805 to 2340) |
| US$43 478 | −956 | (−1599 to −798) | 3003 | (2424 to 3206) |

Costs are in 2011–2012 UK£ and US$. Figures are expected values per patient with 95% CIs in brackets. The point estimates are calculated using base case values of the model parameters (deterministic results). The 95% CIs are derived using standard deviations calculated from the 5000 simulations in the probabilistic sensitivity analysis. The MNB is calculated at a maximum willingness to pay for a QALY of £20,000 ($28 986) and £30,000 ($43 478). Numbers may not sum because of rounding.