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LA CHIRURGIA DEL TUMORE DEL PANCREAS

Dott. M. Garatti, Dott. A.Manzoni

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- ***Surgery is the only potentially curative treatment***
- ***Intervento solo per 15-20% dei pazienti***
- Candidati all'intervento
- Correzione dell'ittero
- Descrizione degli interventi
- Take home messages

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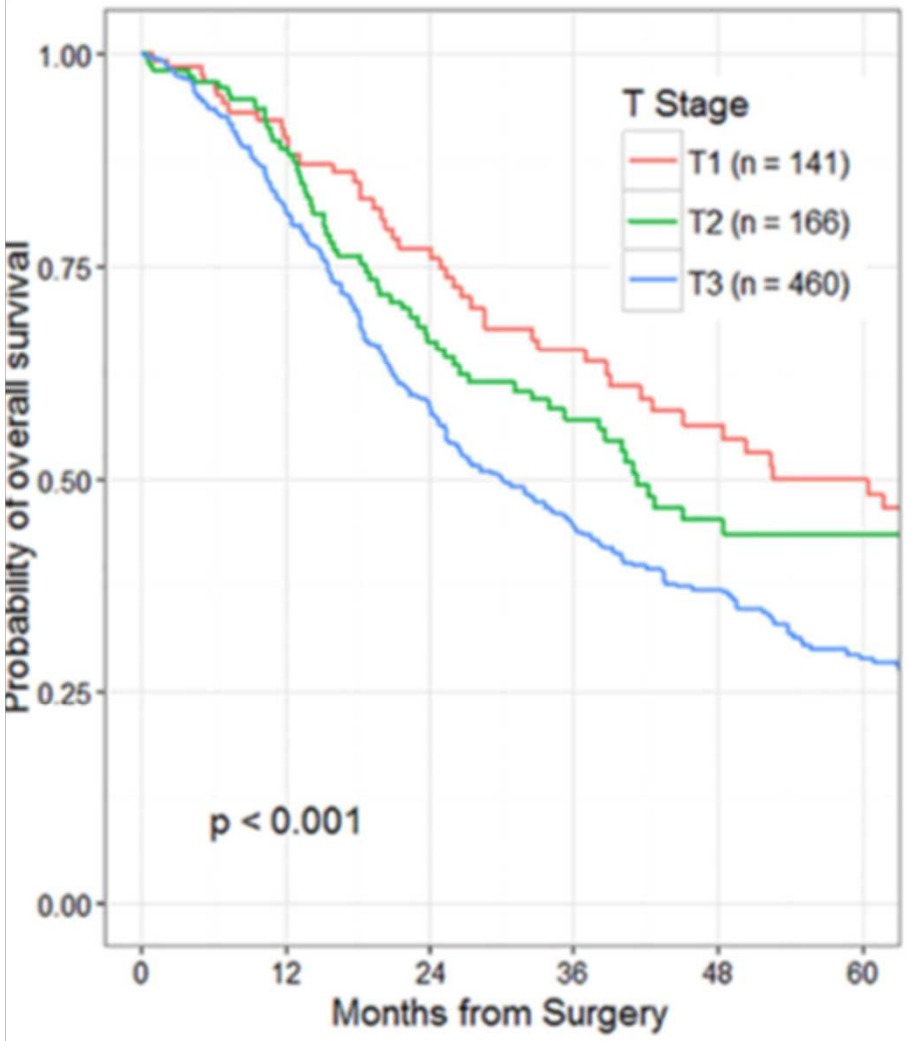
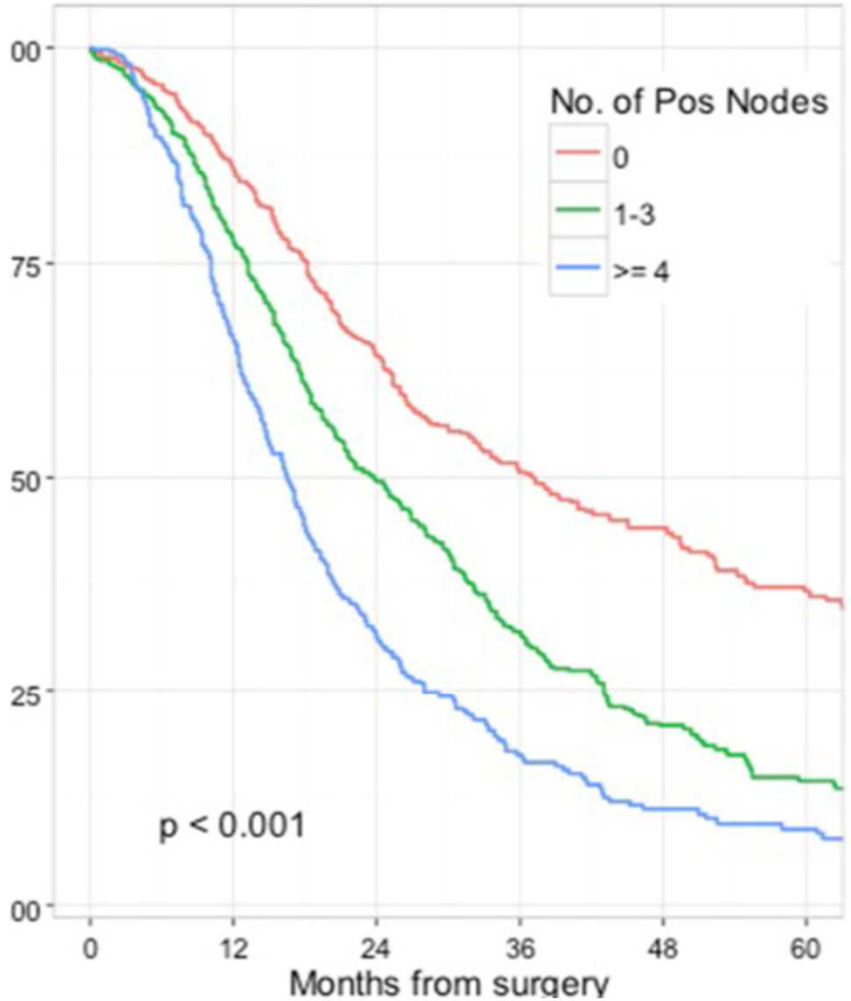
Surgery is the only potentially curative treatment





Pazienti metastatici sono esclusi(eccezioni??)

Radical surgery of oligometastatic pancreatic cancer

T. Hackert [a], W. Niesen [a], U. Hinz, C. Tjaden, O. Strobel, A. Ulrich, C.W. Michalski, M.W. Büchler*

Pazienti Border line resectable

Pazienti con malattia limitata all'organo

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Anatomy	NCCN 2014	AHPBA/SSAT/SSO	MD Anderson Cancer Center	ISGPS	ACTO
Superior mesenteric vein/portal vein	Involvement with distortion/narrowing and/or occlusion amenable to reconstruction	Abutment, encasement, or short-segment occlusion amenable to reconstruction	Short-segment occlusion amenable to reconstruction	Involvement with distortion/narrowing and/or occlusion amenable to reconstruction	Tumor-vessel interface ≥180° and/or occlusion amenable to reconstruction
Superior mesenteric artery	Abutment (≤180°)	Abutment (≤180°)	Abutment (≤180°)	Abutment (≤180°)	Tumor-vessel interface <180°
Common hepatic artery	Abutment or short-segment encasement	Abutment or short-segment encasement	Short segment encasement/ abutment	Abutment or short-segment encasement	Short-segment tumor-vessel interface (any degree) amenable to reconstruction
Celiac artery	No abutment or encasement	No abutment/ encasement	No abutment or encasement	No abutment or encasement	Tumor-vessel interface <180°

NCCN, National Comprehensive Cancer Network; AHPBA/SSAT/SSO, American Hepato-Pancreato-Biliary Association/Society for Surgery of the Alimentary Tract/Society of Surgical Oncology; ISGPS, International Study Group of Pancreatic Surgery; ACTO, Alliance for Clinical Trials in Oncology.

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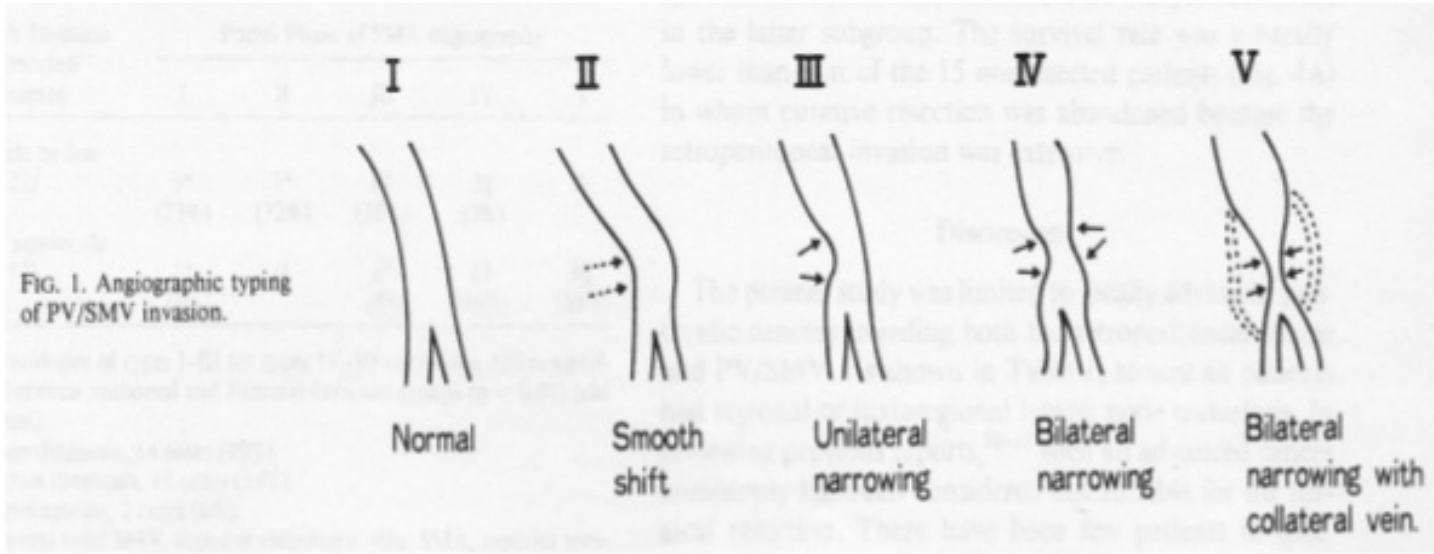

FIG. 1. Angiographic typing of PV/SMV invasion.

Annals of Surgery 1992;215:231-235

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MD. Anderson Cancer Centre

TYPE A	VESSELS
TYPE B	SUSPECTED METASTATIC DISEASE OR N1
TYPE C	POOR PERFORMANCE DUE TO REVERSIBLE CAUSES (MALNUTRITION, ANOREXIA SEPSIS)

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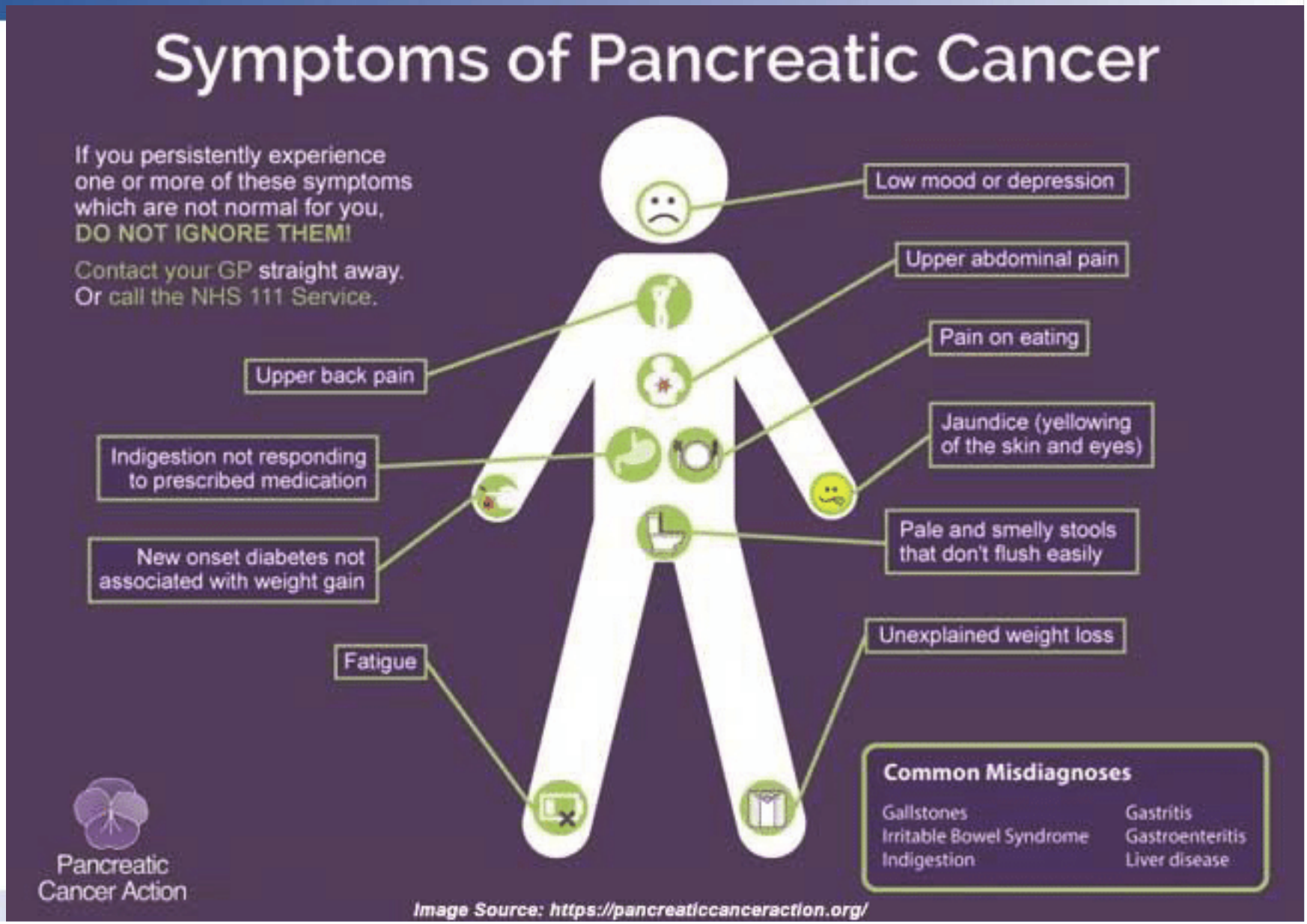
PRESENTAZIONE



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The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Preoperative Biliary Drainage for Cancer of the Head of the Pancreas

Niels A. van der Gaag, M.D., Erik A.J. Rauws, M.D., Ph.D., Casper H.J. van Eijck, M.D., Ph.D., Marco J. Bruno, M.D., Ph.D., Erwin van der Harst, M.D., Ph.D., Frank J.G.M. Kubben, M.D., Ph.D., Josephus J.G.M. Gerritsen, M.D., Ph.D., Jan Willem Greve, M.D., Ph.D., Michael F. Gerhards, M.D., Ph.D., Ignace H.J.T. de Hingh, M.D., Ph.D., Jean H. Klinkenbijl, M.D., Ph.D., Chung Y. Nio, M.D., Steve M.M. de Castro, M.D., Ph.D., Olivier R.C. Busch, M.D., Ph.D., Thomas M. van Gulik, M.D., Ph.D., Patrick M.M. Bossuyt, Ph.D., and Dirk J. Gouma, M.D., Ph.D.*

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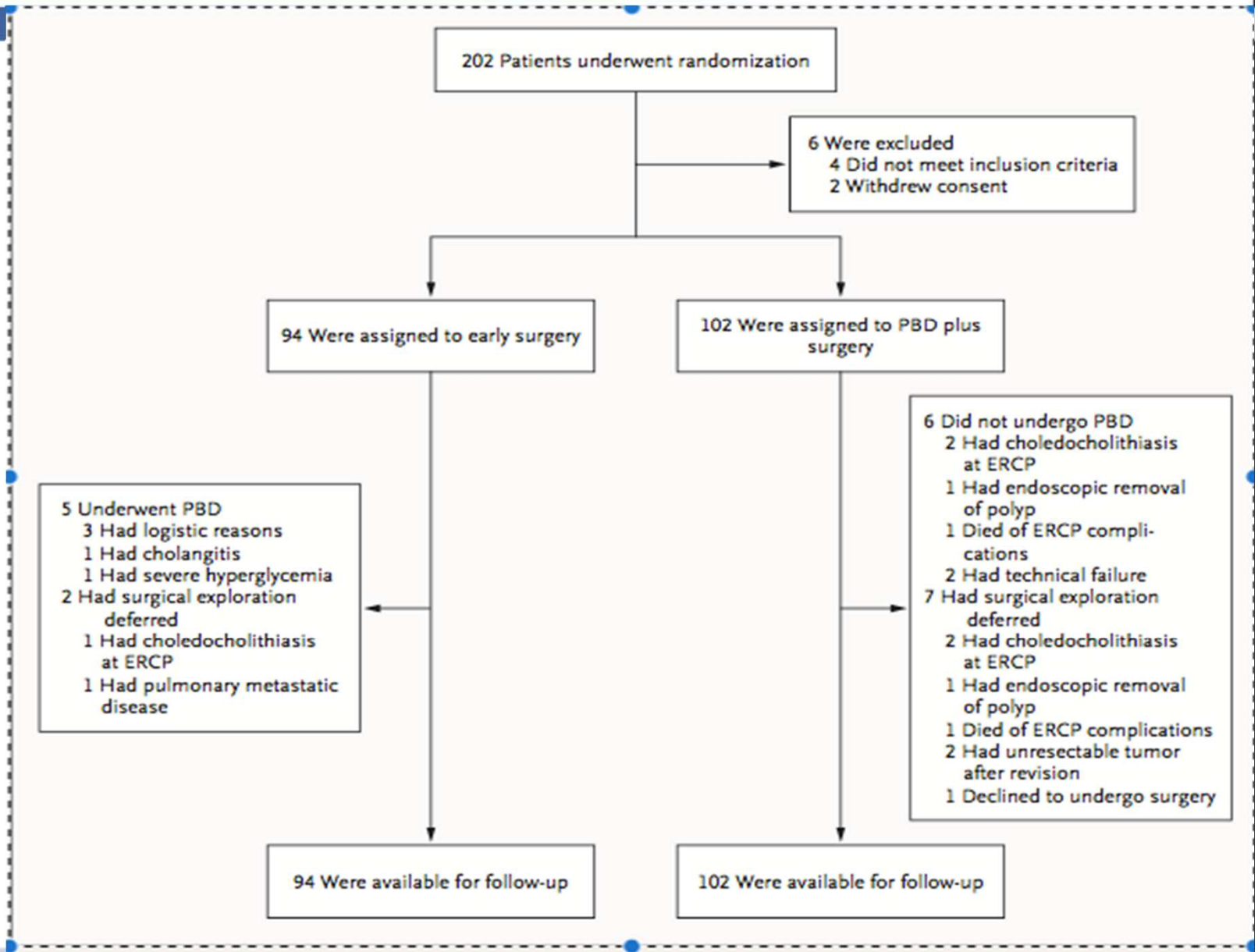

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SURGERY FIRST IN 1 WEEK

BILIRUBIN> 14 EXCLUDED (mean bilirubin 150 microm/l, 8.7 mg%)

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Related to surgery		
Any	35 (37)	48 (47)
Pancreaticojejunostomy leakage§	11 (12)	8 (8)
Grade A	1 (1)	0
Grade B	4 (4)	4 (4)
Grade C	6 (6)	4 (4)
Hemorrhage after pancreatectomy‡	4 (4)	2 (2)
Delayed gastric emptying	9 (10)	18 (18)
Biliary leakage	3 (3)	1 (1)
Gastrojejunostomy or duodenojejunostomy leakage	2 (2)	4 (4)
Intraabdominal abscess	3 (3)	2 (2)
Wound infection	7 (7)	13 (13)
Portal-vein thrombosis	1 (1)	0
Pneumonia	5 (5)	9 (9)
Cholangitis	3 (3)	3 (3)
Myocardial infarction	0	4 (4)
Need for repeated laparotomy¶	13 (14)	12 (12)

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Complication	Early Surgery (N=94)	Preoperative Biliary Drainage (N=102)
	no. (%)	
Related to preoperative biliary drainage		
Any	2 (2)	47 (46)
Pancreatitis	0	7 (7)
Cholangitis†	2 (2)	27 (26)
Perforation	0	2 (2)
Hemorrhage after ERCP‡	0	2 (2)
Related to stent		
Occlusion	1 (1)	15 (15)
Need for exchange	2 (2)	31 (30)

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OPEN

A Meta-Analysis of the Effect of Preoperative Biliary Stenting on Patients With Obstructive Jaundice

Chengyi Sun, MD, Guirong Yan, MM, Zhiming Li, ScD, and Chi-Meng Tzeng, PhD

Thus, we believe that preoperative biliary drainage should not be routinely applied. However, for patients with severe jaundice (serum bilirubin level 150 mm/L), concomitant cho- langitis, or severe malnutrition and patients who need a rela- tively long preoperative assessment and wait for a relatively long time before the surgery, preoperative drainage may be selectively applied.38 We suggest that the drainage time should >4 weeks, and metal stents should be used for drainage.

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Systematic review and meta-analysis of metal versus plastic stents for preoperative biliary drainage in resectable periampullary or pancreatic head tumors

S. Crippa [a], R. Cirocchi [b], S. Partelli [a], M.C. Petrone [c], F. Muffatti [a], C. Renzi [d], M. Falconi [a,*], P.G. Arcidiacono [c]

Results: One RCT and four non-RCTs were selected, including 704 patients. Of these, 202 patients (29.5%) were treated with metal stents and 502 (70.5%) with plastic stents. The majority of patients (86.4%) had pancreatic cancer. The rate of endoscopic re-intervention after preoperative biliary drainage was significantly lower in the metal stent (3.4%) than in the plastic stent (14.8%) group ($p < 0.0001$). The rate of postoperative pancreatic fistula was significantly lower in the meta stent group as well (5.1% versus 11.8%, $p = 0.04$). The rate of post-operative surgical complications and of − post-operative mortality did not differ between the two groups.

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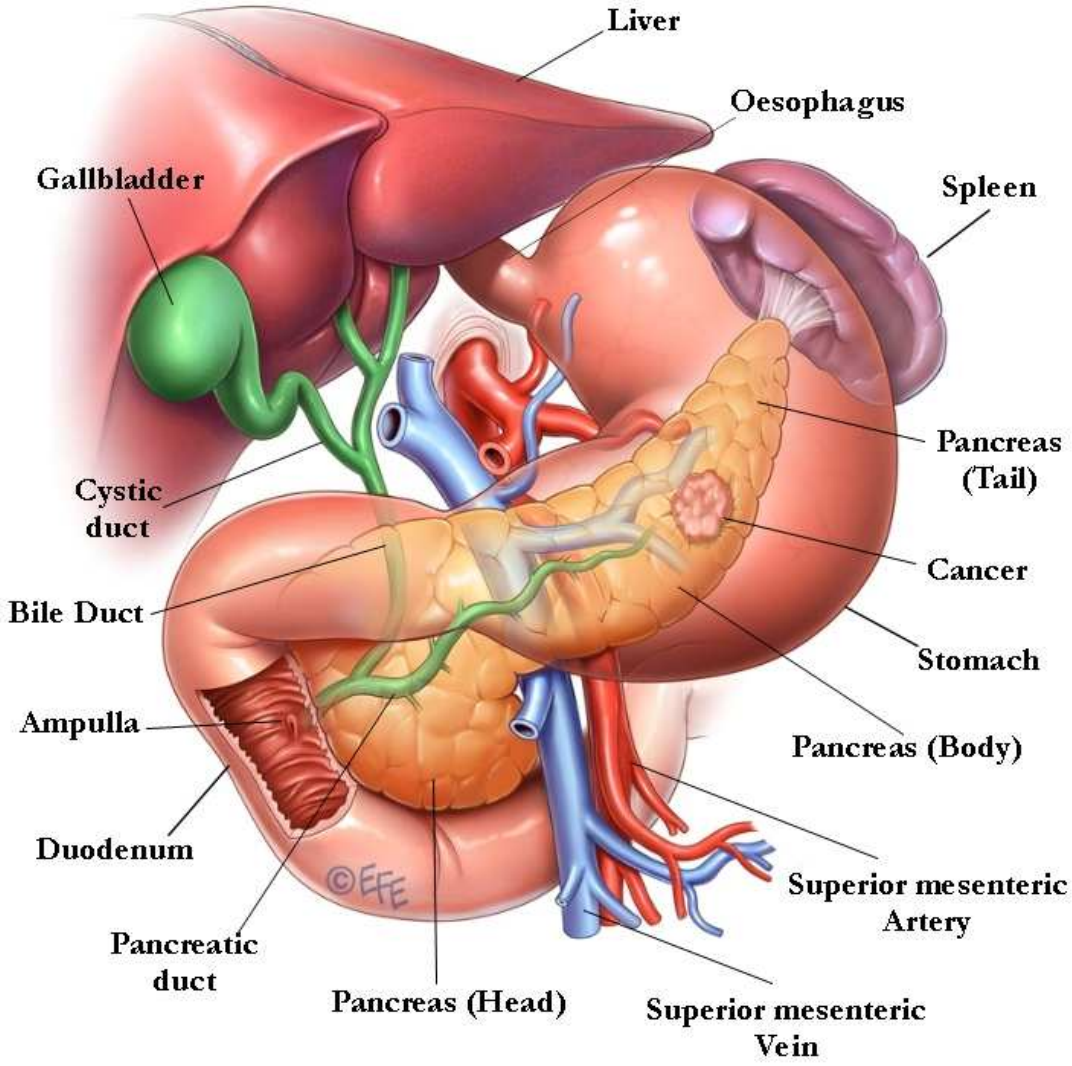
Resezioni Pancreatiche



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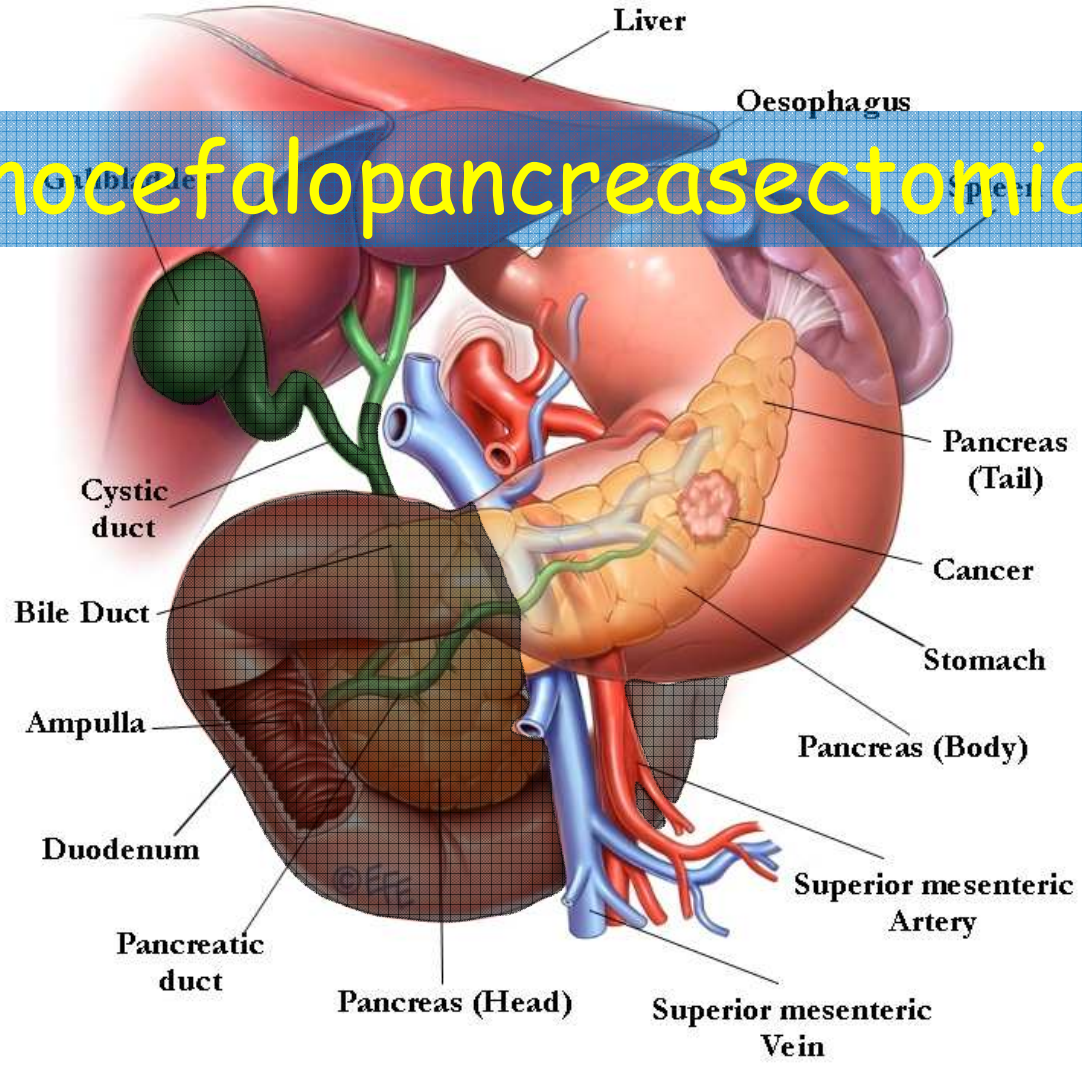
Resezioni Pancreatiche

Duodenocefalopancreasectomia (DCP)



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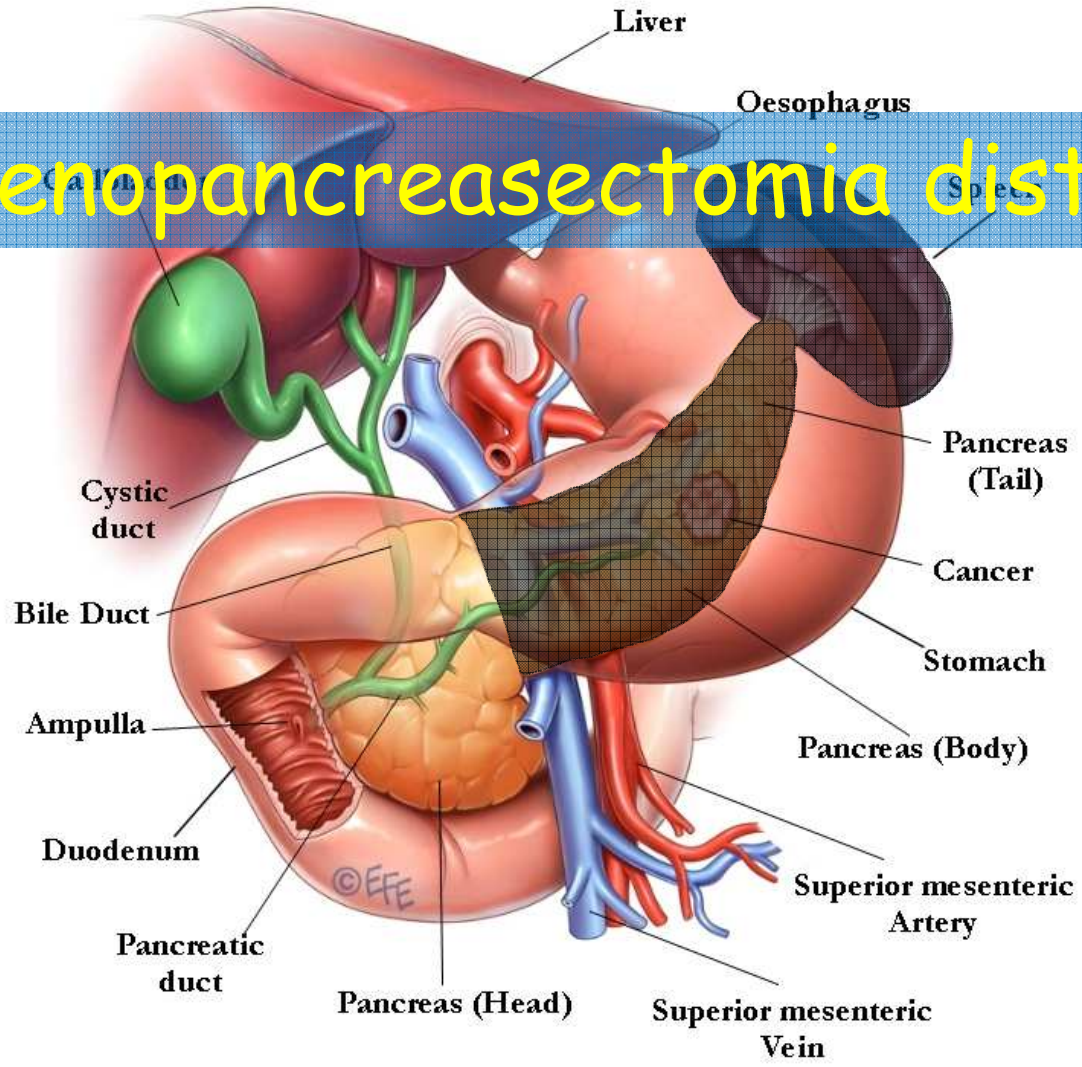
Resezioni Pancreatiche

Splenopancreasectomia distale



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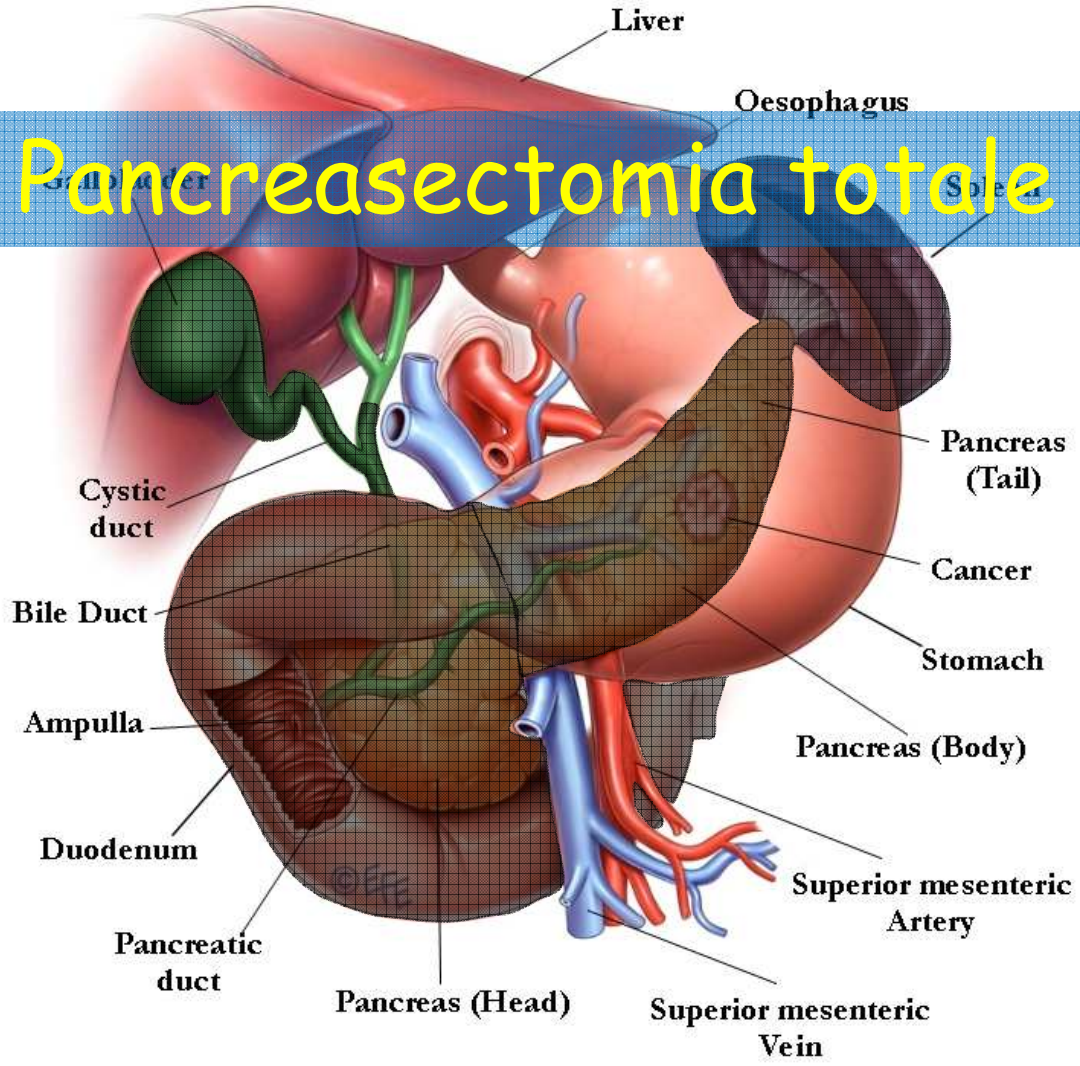
Resezioni Pancreatiche

Pancreasectomia totale



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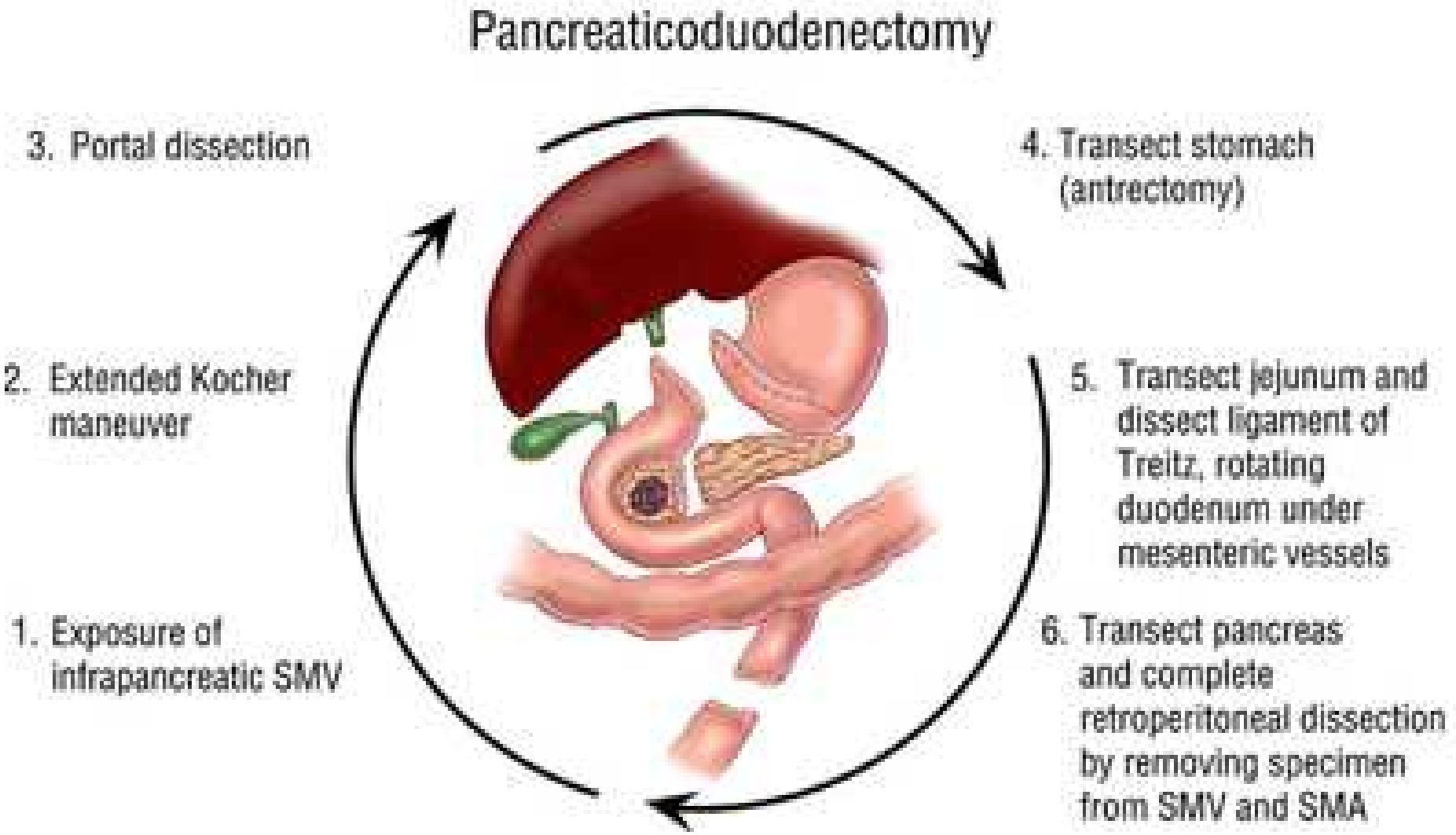
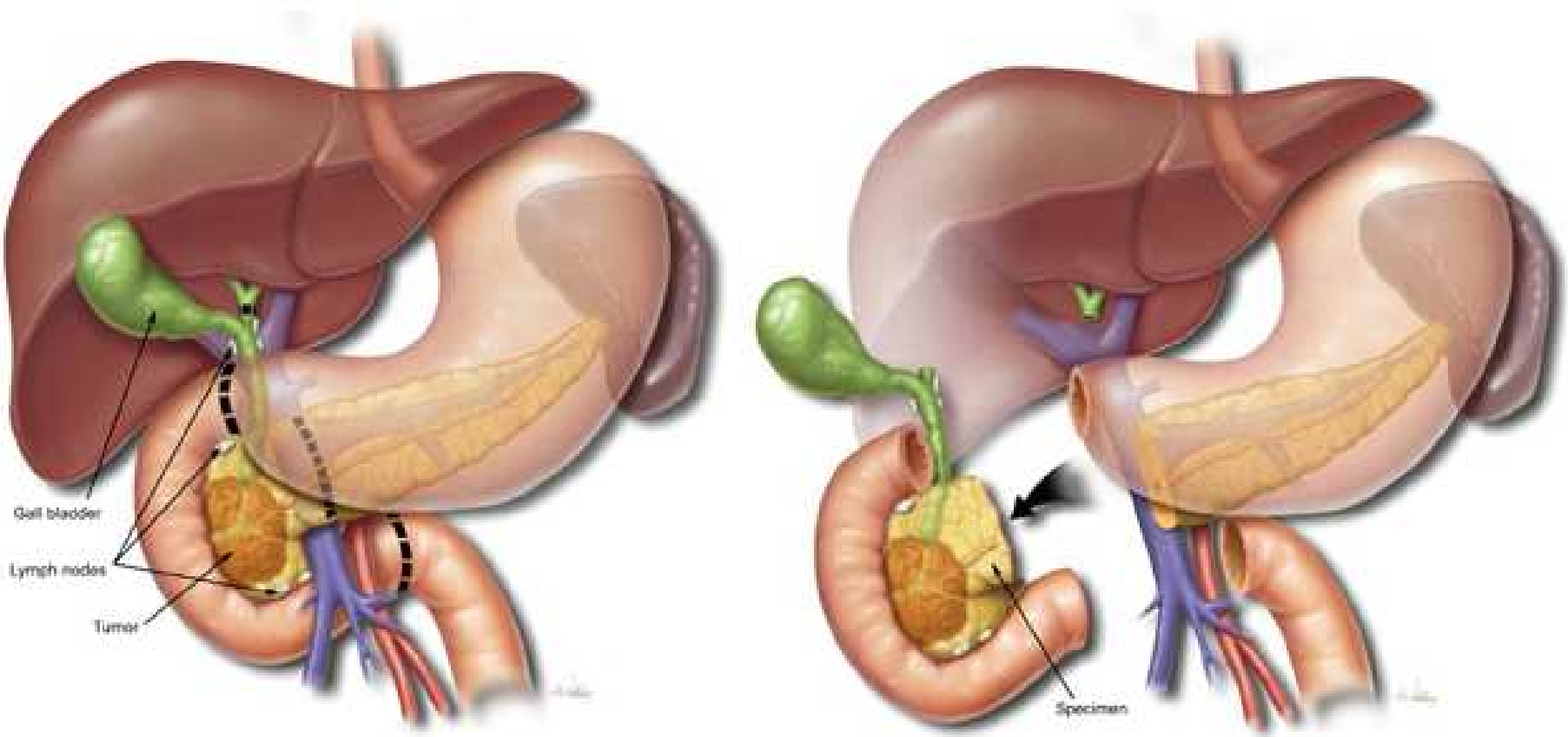
Duodenocefalopancreasectomia (DCP)



Duodenocefalopancreasectomia (DCP)

FASE DEMOLITIVA



Duodenocefalopancreasectomia (DCP)

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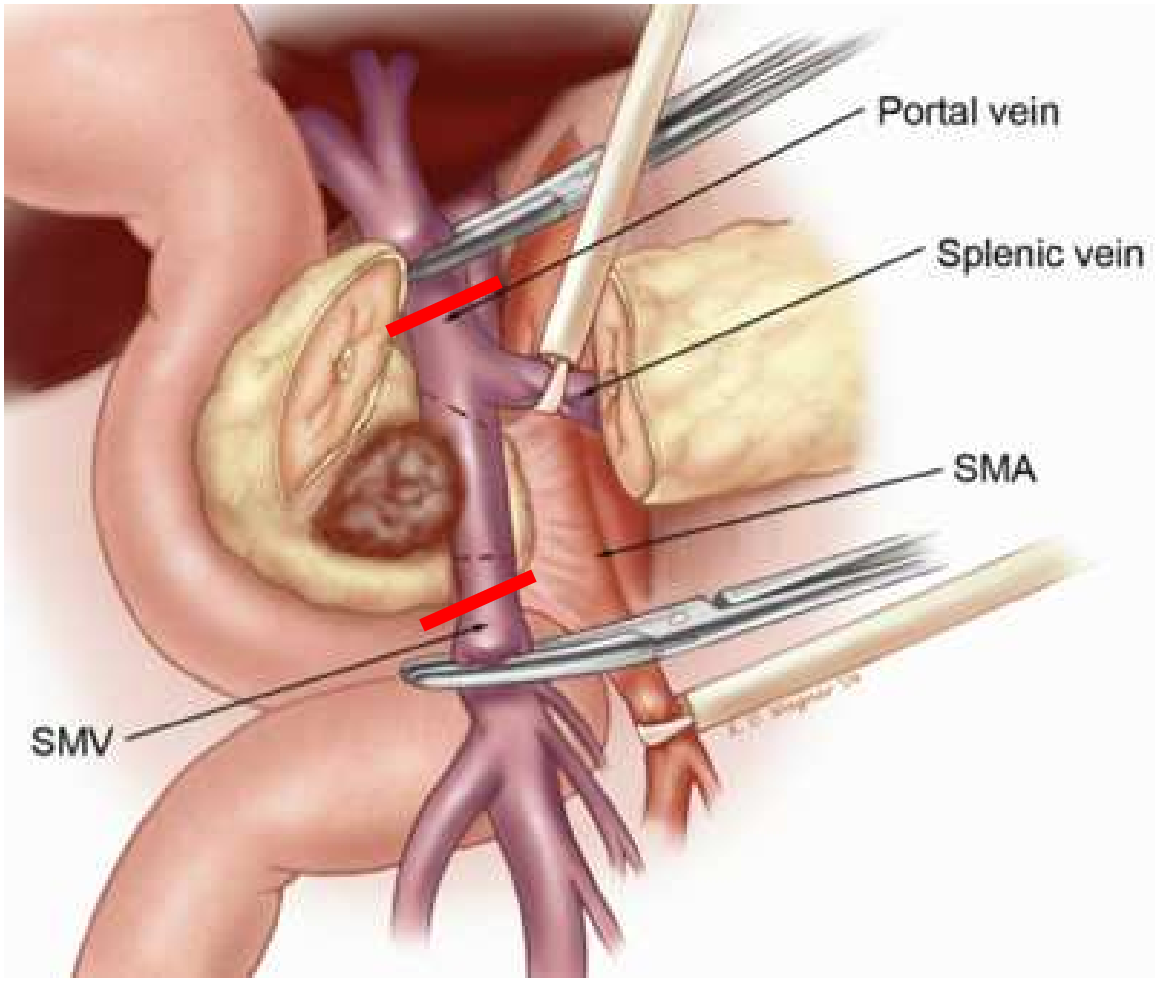

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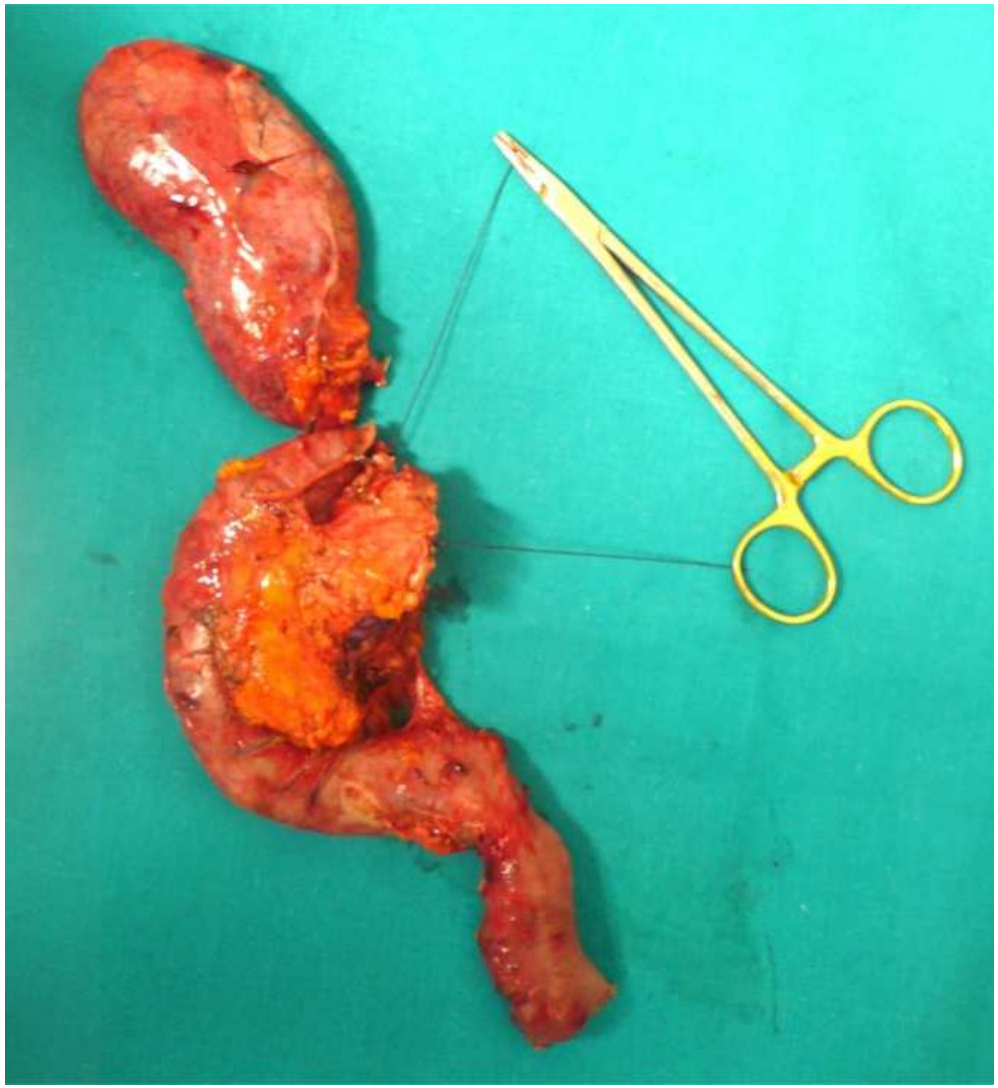
Duodenocefalopancreasectomia (DCP)



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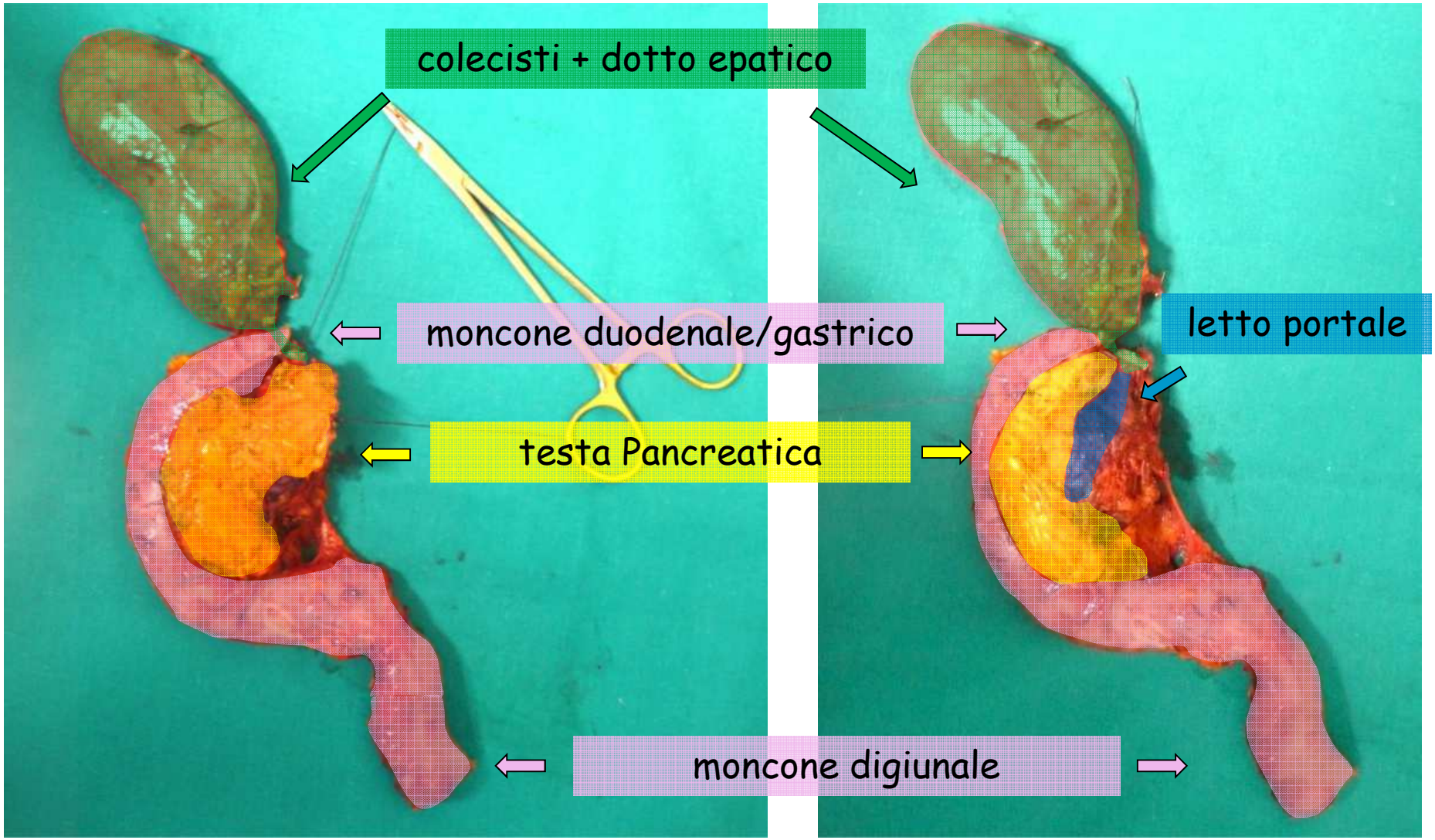
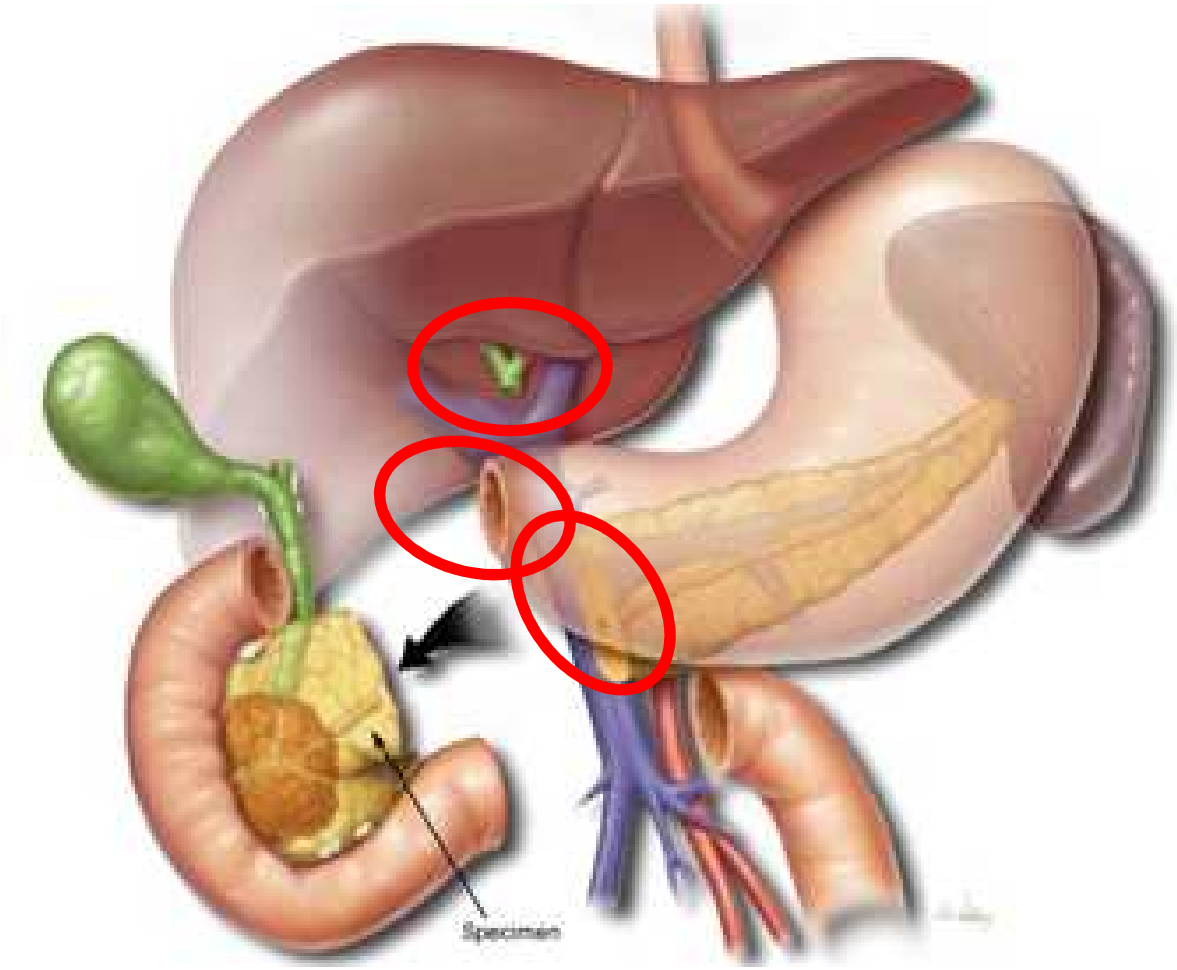
Duodenocefalopancreasectomia (DCP)



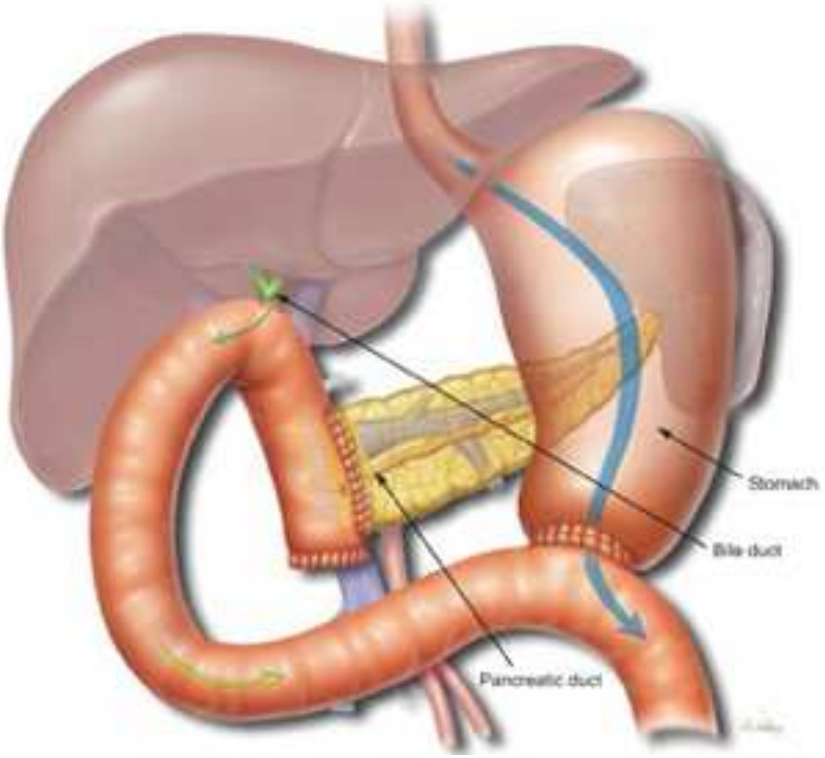
Duodenocefalopancreasectomia (DCP)

FASE RICOSTRUTTIVA

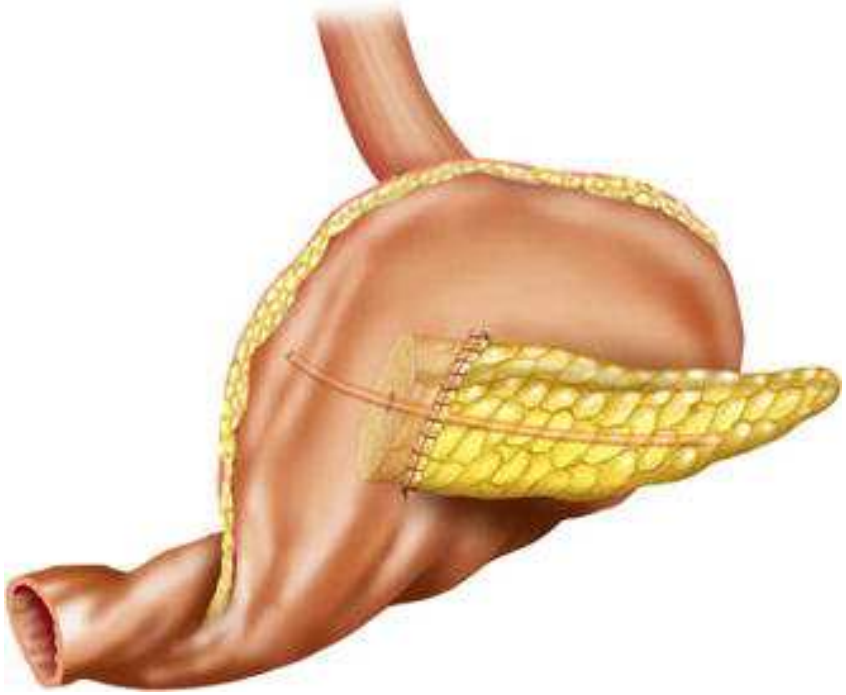


Duodenocefalopancreasectomia (DCP)

FASE RICOSTRUTTIVA



Pancreo-digiunoanastomosi



Pancreo-gastroanastomosi

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Duodenocefalopancreasectomia (DCP)

Author	N°Patients	Outcome
Yeo	73PG/72PJ	No difference fistula rate
Bassi	69PG/82PJ	No difference fistula rate, less biliary fistula and abdominal collection in Pg
Duffas	81PG/68PJ	No difference in intrabdominal complication or fistula rate
Fernandez-Cruz	108 pts	Fistula rate 4% in Pg vs 18% Pj
Wellner	59PG/57PJ	No difference fistula rate, DGE or bleeding. Shorter operation in Pg
Topal	162PG/167PJ	Fistula rate 8% in Pg vs 18.9% in Pj
Figueras	65PG/58PJ	Rate and severity lower with Pg
El Nakeeb	45PG/45PJ	Non difference in fistula rate
“Recopanc “	171PG/149PJ	No difference in grade B,C fistula, >grade A and B bleeding in Pg. Less experienced surgeon better with Pg

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Duodenocefalopancreasectomia (DCP)

Cochrane Library
Cochrane Database of Systematic Reviews

Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD012257.
DOI: 10.1002/14651858.CD012257.pub2.

Pancreaticojejunostomy versus pancreaticogastrostomy reconstruction for the prevention of postoperative pancreatic fistula following pancreaticoduodenectomy (Review)

Cheng Y, Briarava M, Lai M, Wang X, Tu B, Cheng N, Gong J, Yuan Y, Pilati P, Mocellin S

Our findings suggest that there is no reliable evidence supporting the use of one surgical procedure over the other (PJ or PG) to reconstruct the pancreatic stump following pancreatoduodenectomy.

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Duodenocefalopancreasectomia (DCP)

Pancreatic anastomosis after pancreatoduodenectomy: A position statement by the International Study Group of Pancreatic Surgery (ISGPS)

Shailesh V. Shrikhande, MD,[a] Masillamany Sivasanker, MD,[a] Charles M. Vollmer, MD,[b] Helmut Friess, MD,[c] Marc G. Besselink, MD,[d] Abe Fingerhut, MD,[e] Charles J. Yeo, MD,[f] Carlos Fernandez-delCastillo, MD,[g] Christos Dervenis, MD,[h] Christoper Halloran, MD,[i] Dirk J. Gouma, MD,[d] Dejan Radenkovic, MD,[j] Horacio J. Asbun, MD,[k] John P. Neoptolemos, MD,[i] Jakob R. Izbicki, MD,[l] Keith D. Lillemoe, MD,[g] Kevin C. Conlon, MD,[m] Laureano Fernandez-Cruz, MD,[n] Marco Montorsi, MD,[o] Max Bockhorn, MD,[l] Mustapha Adham, MD,[p] Richard Charnley, MD,[q] Ross Carter, MD,[r] Thilo Hackert, MD,[s] Werner Hartwig, MD,[t] Yi Miao, MD,[u] Michael Sarr, MD,[v] Claudio Bassi, MD,[w] *and* Markus W. Büchler, MD,[s] for the International Study Group of Pancreatic Surgery (ISGPS) *Mumbai, India, Philadelphia, PA, Munich, Hamburg, and Heidelberg, Germany, Amsterdam, The Netherlands, Graz, Austria, Boston, MA, Athens, Greece, Liverpool, Newcastle upon Tyne, and Glasgow, United Kingdom, Belgrade, Serbia, Jacksonville, FL, Dublin, Ireland, Barcelona, Spain, Lyon, France, Nanjing, P.R. China, Rochester, MN, and Verona and Milan, Italy*

Surgery
Volume 161, Number 5

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Duodenocefalopancreasectomia (DCP)

Variables	*Literature review summary data*	*Level of evidence (1 to 5) and evidence-based recommendation (A to D)*	*ISGPS recommendation (Strong, Moderate, Weak)*	*Justification*
PG vs PJ	PG apparently seems advantageous over PJ although varied heterogeneity seen in existing RCTs	Level 1B Grade B	Moderate	High level of heterogeneity observed in evidence.

A consistent practice of a standardized technique may be a potential strategy to decrease the rate of CR-POPFs for surgeons early in their career, but experienced surgeons at high-volume centers can have lower POPF rates performing a variety of techniques in diverse situations (Table II).

Duodenocefalopancreasectomia (DCP)

Open vs mini-invasiva

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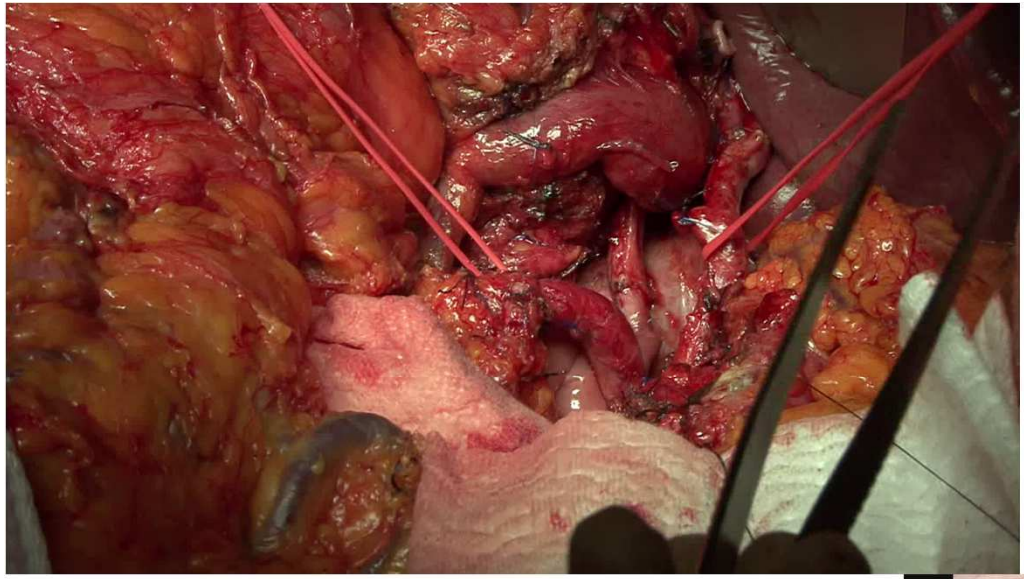
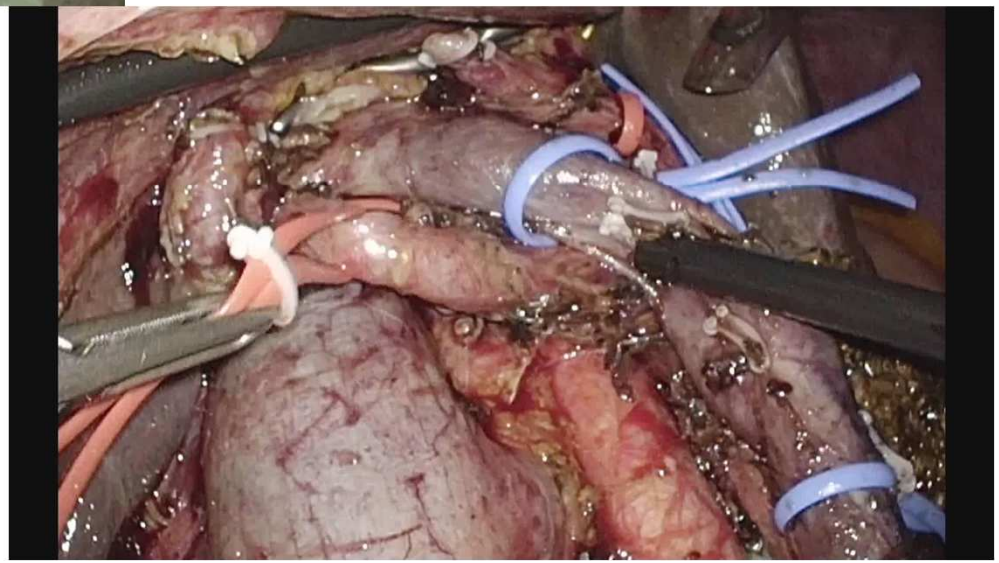
Duodenocefalopancreasectomia (DCP)



Open

Laparoscopia



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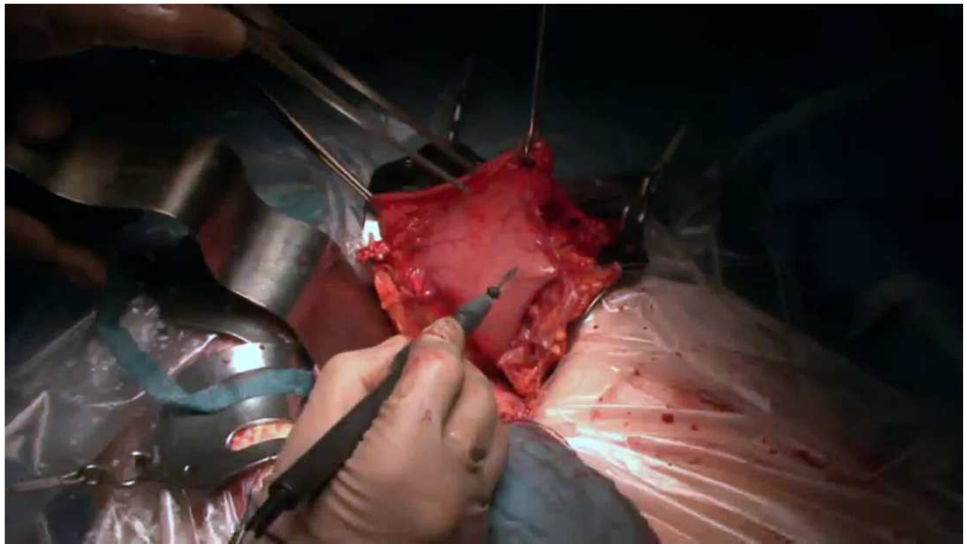
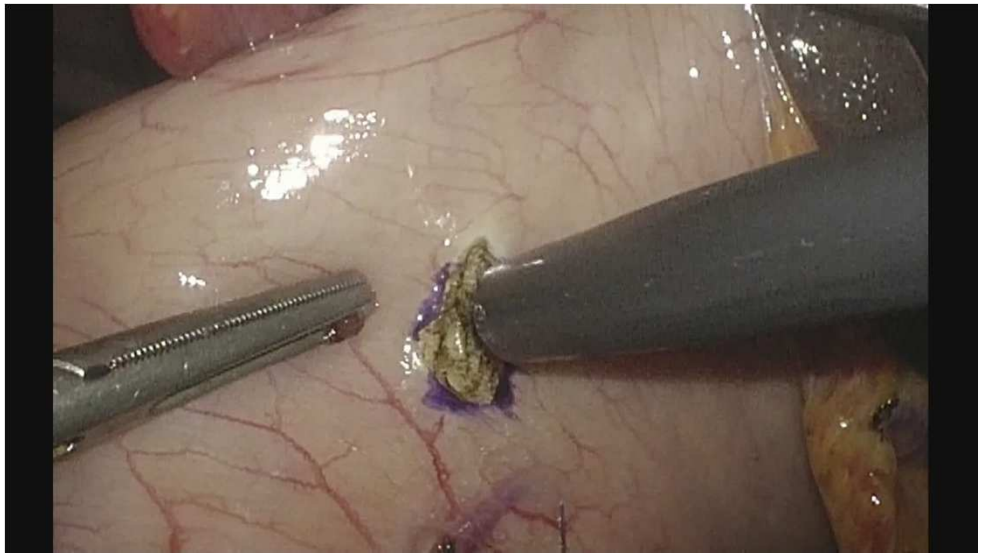
Duodenocefalopancreasectomia (DCP)



Open

Laparoscopia



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Duodenocefalopancreasectomia (DCP)

ORIGINAL ARTICLE

Minimally invasive pancreatoduodenectomy

Michael L. Kendrick[1], Jony van Hilst[2], Ugo Boggi[3], Thijs de Rooij[2], R. Matthew Walsh[4], Herbert J. Zeh[5], Steven J. Hughes[6], Yoshiharu Nakamura[7], Charles M. Vollmer[8], David A. Kooby[9], Horacio J. Asbun[10] & the Minimally Invasive Pancreatic Resection Organizing Committee

[1]Mayo Clinic, Rochester, MN, USA, [2]Academic Medical Center, Amsterdam, The Netherlands, [3]University of Pisa, Pisa, Italy, [4]Cleveland Clinic, Cleveland, OH, [5]University of Pittsburgh, Pittsburgh, PA, [6]University of Florida, Gainesville, FL, USA, [7]Nippon Medical School, Tokyo, Japan, [8]University of Pennsylvania, Philadelphia, PA, [9]Emory University, Atlanta, GA, and [10]Mayo Clinic, Jacksonville, FL, USA

HPB 2017, 19, 215–224

Conclusion: MIPD appears to provide similar perioperative and oncologic outcomes in selected patients, when performed at experienced, high-volume centers. Its overall role in pancreatoduodenectomy needs to be better defined. Improved training opportunities, registry participation and prospective evaluation are needed.

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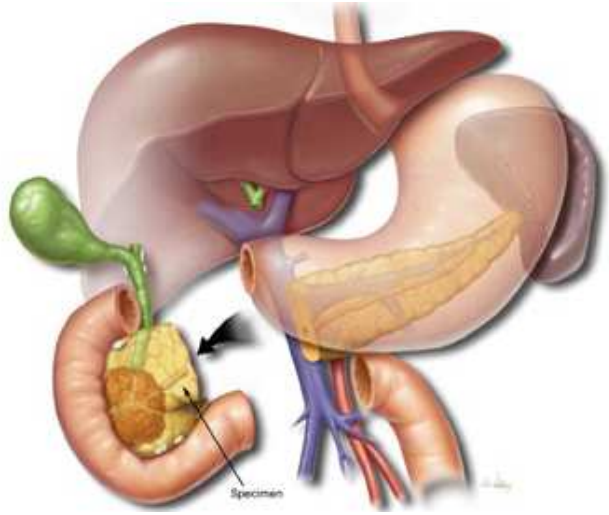
Duodenocefalopancreasectomia (DCP)



- ✓ Intervento complesso con alta probabilità di complicanze peri ed intraoperatorie

- ✓ A lungo termine attenzione allo stato di nutrizione (rischio diarree; insufficienza pancreatica esocrina; diabete)

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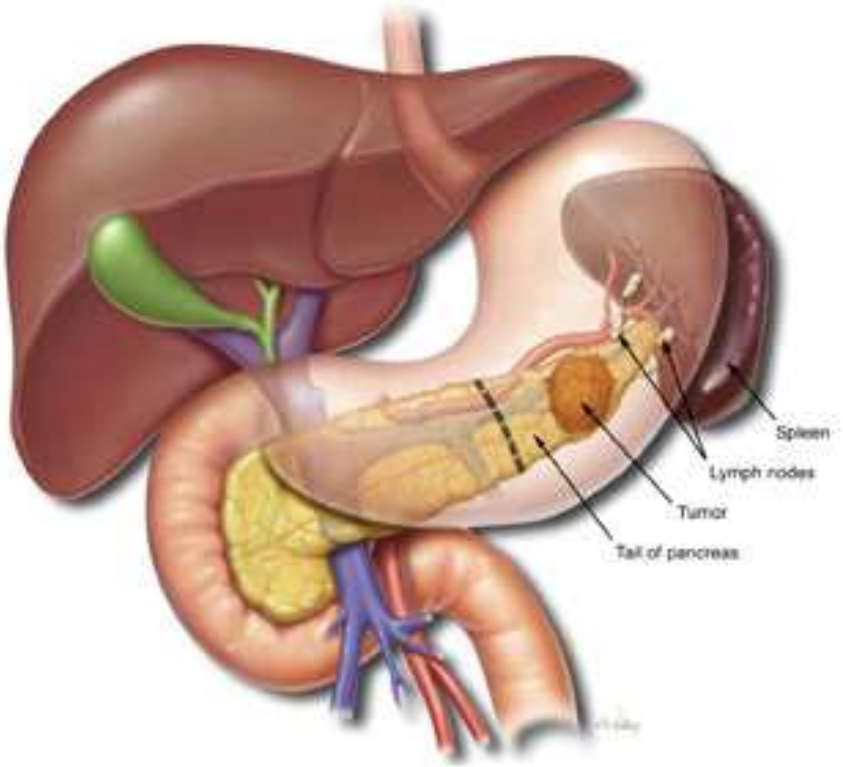
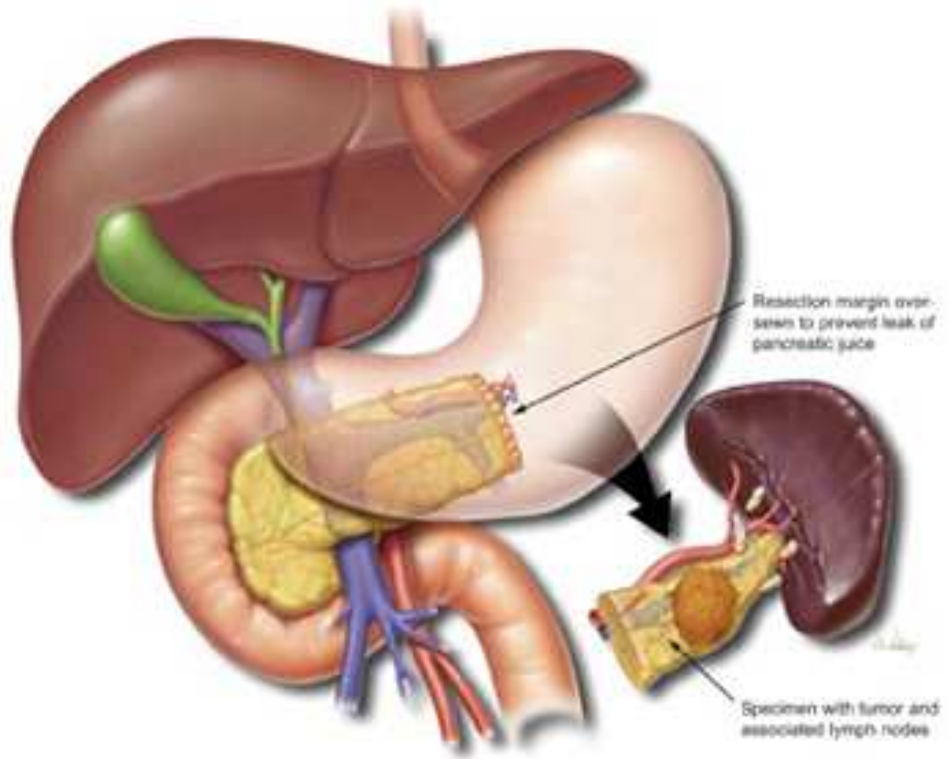
Splenopancreasectomia distale

FASE DEMOLITIVA





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Splenopancreasectomia distale

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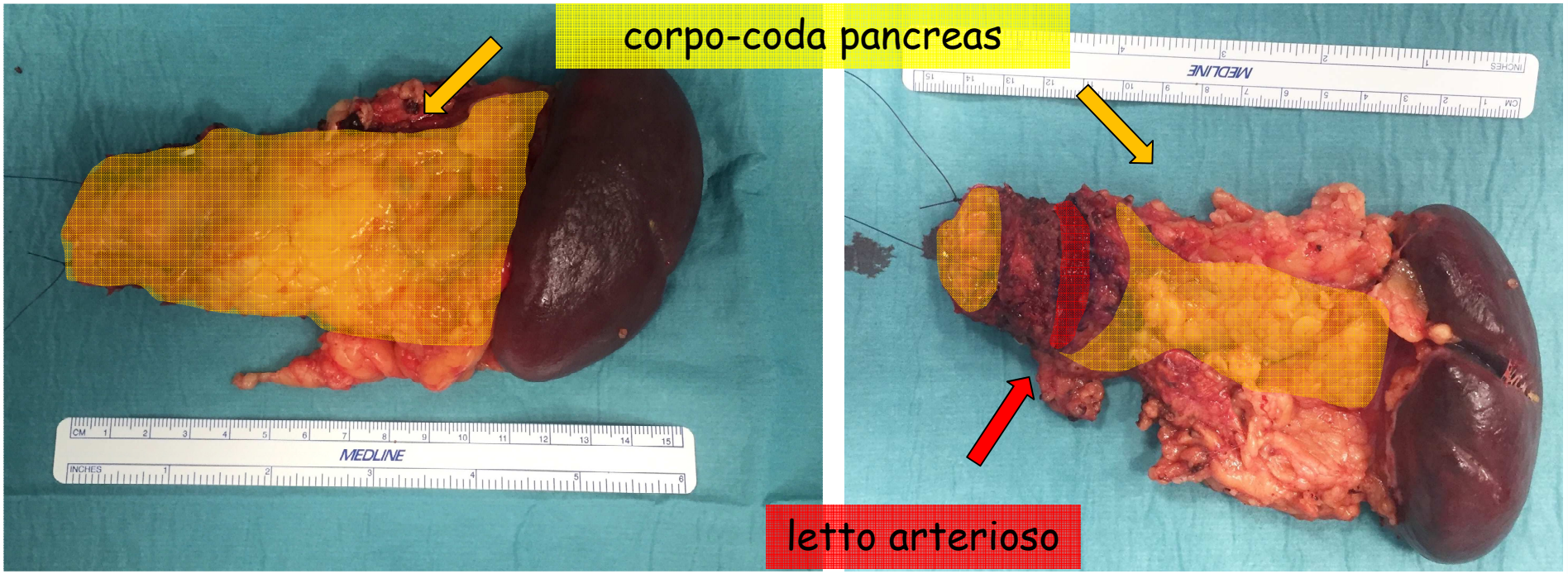
Splenopancreasectomia distale



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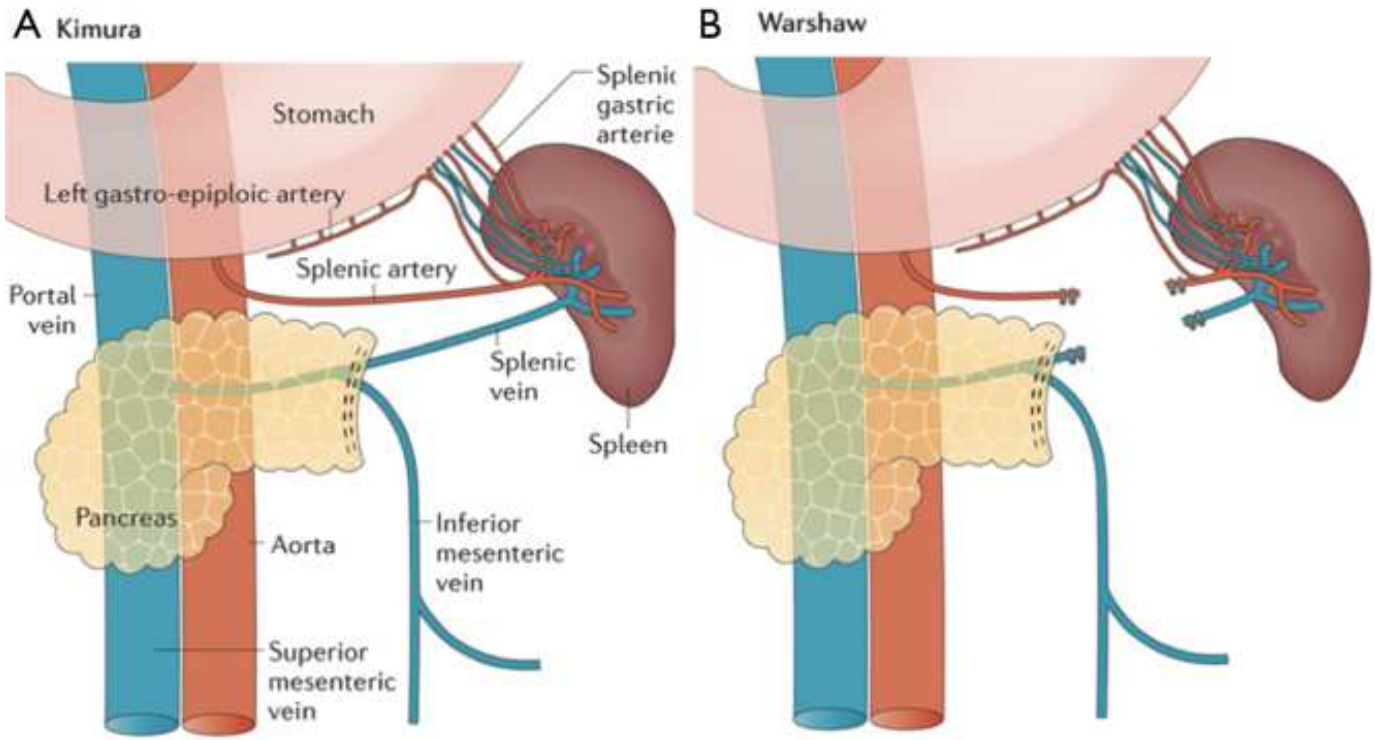
Splenopancreasectomia distale

Spleen preserving????????



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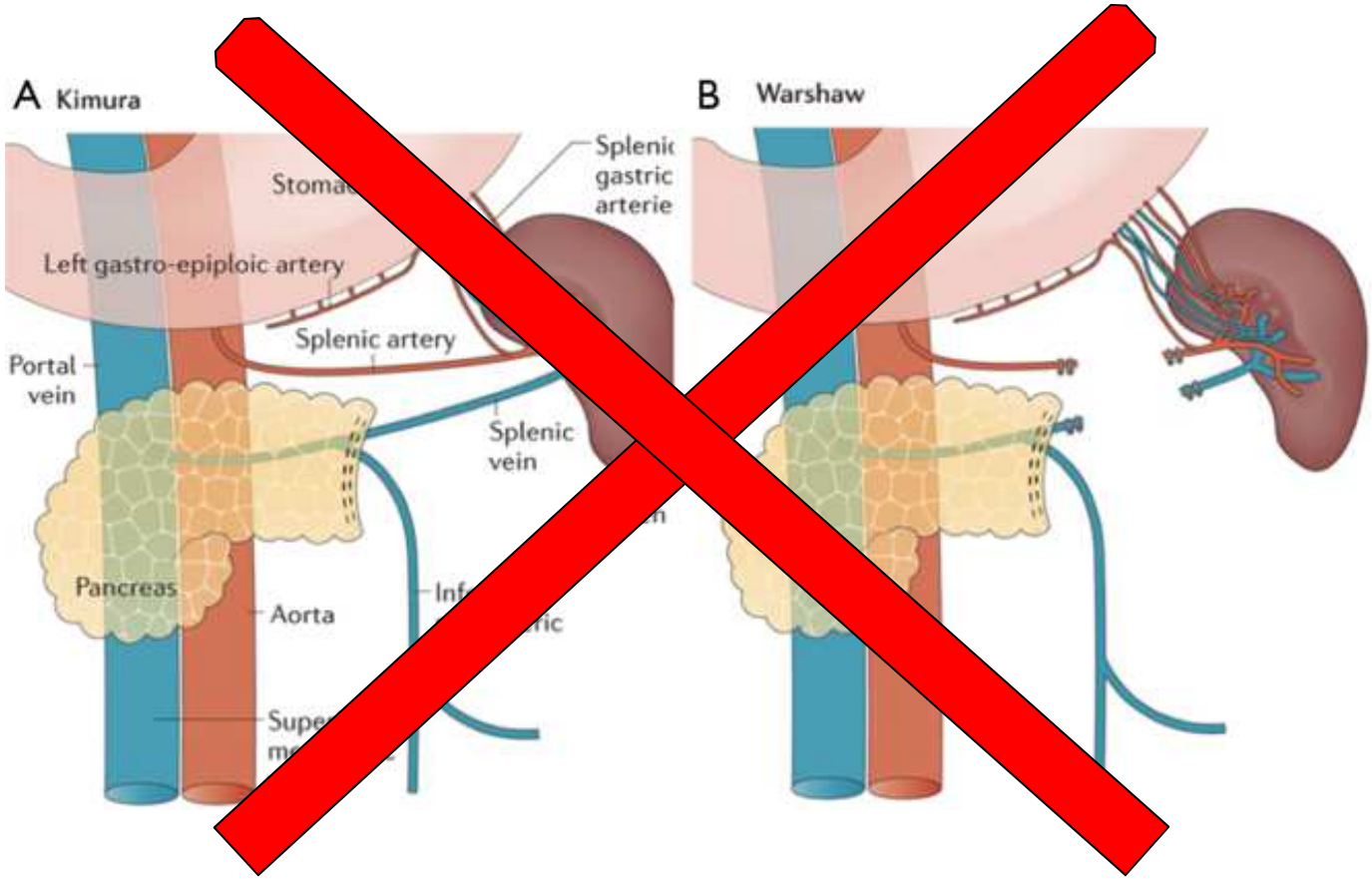
Splenopancreasectomia distale

Spleen preserving????????



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Splenopancreasectomia distale

Consensus

Surgery
September 2014

Definition of a standard lymphadenectomy in surgery for pancreatic ductal adenocarcinoma: A consensus statement by the International Study Group on Pancreatic Surgery (ISGPS)

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Consensus statement. Standard lymphadenectomy during pancreatectomy for patients with pancreatic ductal adenocarcinoma in the body or tail includes Ln's in stations 10 in the hilum of the spleen, 11 along the splenic artery, and 18 along the inferior border of the body and tail of the pancreas. Ln station 9 is only suggested to be included in the resection when tumors are confined to the area of the body of the pancreas (Fig 5).

Members of the consensus conference also agreed that in patients undergoing left-sided pancreatectomy for malignant neoplasms, splenectomy is indicated to ensure adequate excision of the primary tumor and Ln's. The lack of consensus and no available level I evidence on the benefit of extending the resection weakens this consensus statement.

Pattern di recidiva dell'adenocarcinoma pancreatico

25%	liver only
24%	local only
19%	local 6 distant
15%	multiple
15%	lung only
3%	other (bone etc..)

Groot, et al. Ann. Surg 2017,Mar 23

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Groot, et al. Ann. Surg 2017,Mar 23

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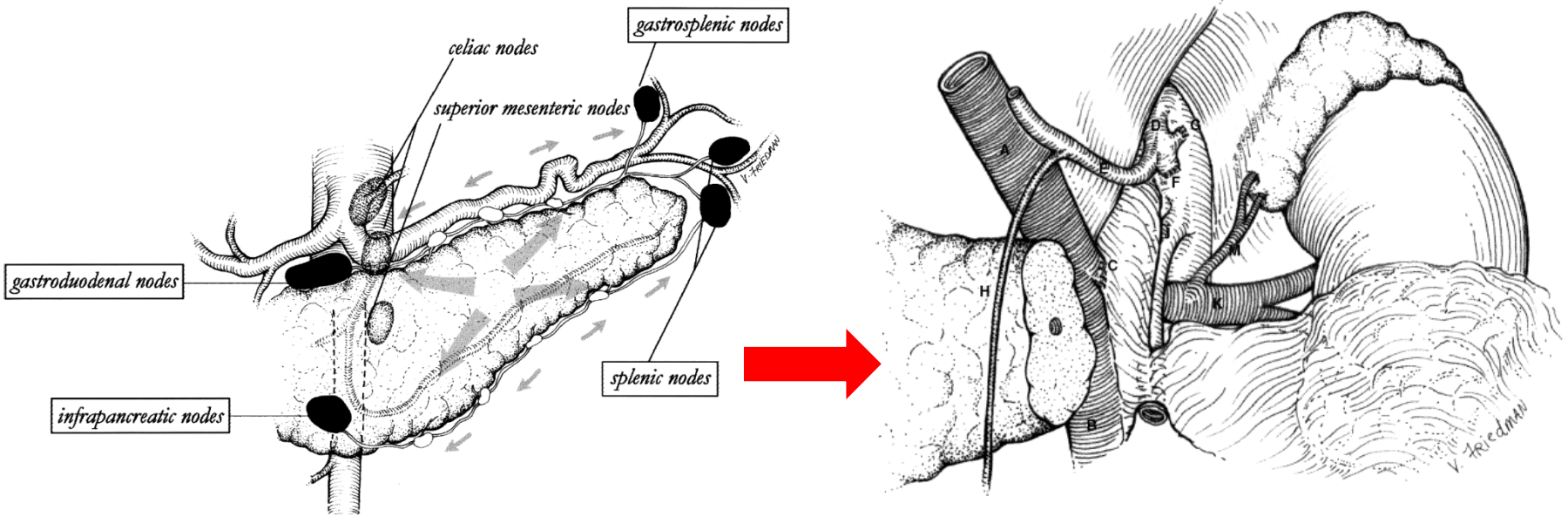
Splenopancreasectomia distale

Radical antegrade modular pancreatosplenectomy

Steven M. Strasberg, MD, Jeffrey A. Drebin, MD, PhD, *and* **David Linehan, MD,** *St. Louis, Mo*

(Surgery 2003;133:521-7.)



Migliore linfoadenectomia

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Splenopancreasectomia distale

Non solo per linfoadenectomia

Radical Antegrade Modular Pancreatosplenectomy Procedure for Adenocarcinoma of the Body and Tail of the Pancreas: Ability to Obtain Negative Tangential Margins

Steven M Strasberg, MD, FACS, David C Linehan, MD, FACS, William G Hawkins, MD

J Am Coll Surg 2007

R0 in 91% of cases

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Splenopancreasectomia distale

Comparison of Surgical Outcomes Between Radical Antegrade Modular Pancreatosplenectomy (RAMPS) and Standard Retrograde Pancreatosplenectomy (SPRS) for Left-Sided Pancreatic Cancer

Toshiya Abe[1] · Kenoki Ohuchida[1] · Yoshihiro Miyasaka[1] · Takao Ohtsuka[1] · Yoshinao Oda[2] · Masafumi Nakamura[1]

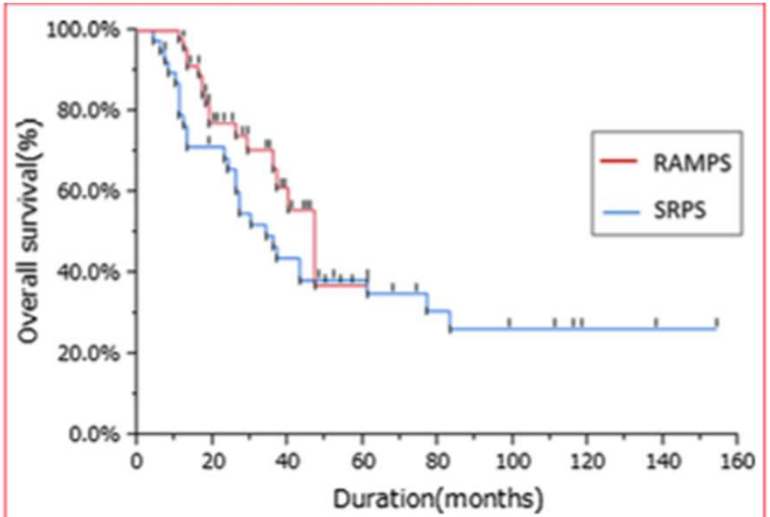

Fig. 1 Overall survival after SRPS and RAMPS for pancreas body and tail adenocarcinoma. In comparing the RAMPS and SRPS groups, RAMPS showed a tendency for improvement of the median survival times than SRPS (47 vs 34 months) ($P = 0.1920$)

World J Surg (2016) 40:2267–2275
DOI 10.1007/s00268-016-3526-x

Open vs mini-invasiva

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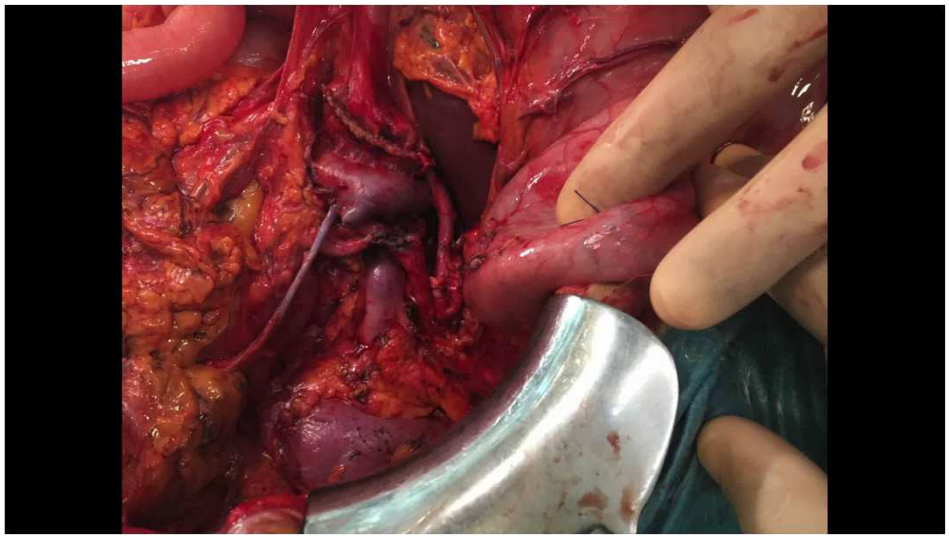
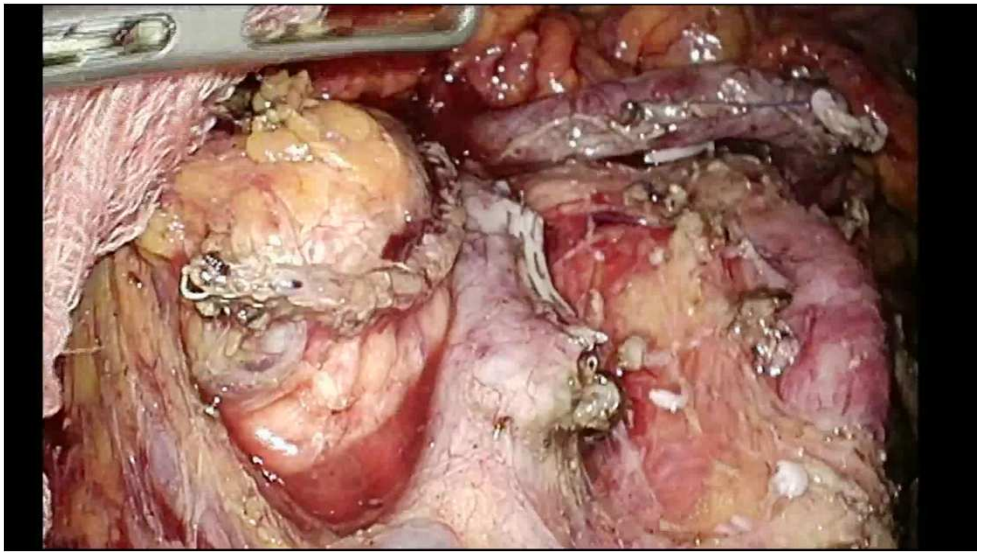


Open

Laparoscopia



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Splenopancreasectomia distale

ORIGINAL ARTICLE

Minimally Invasive versus Open Distal Pancreatectomy for Ductal Adenocarcinoma (DIPLOMA)

A Pan-European Propensity Score Matched Study

Annals of Surgery • Volume XX, Number XX, Month 2017

Conclusions: Comparable survival was seen after MIDP and ODP for PDAC, but the opposing differences in R0 resection rate, resection of Gerota's fascia, and lymph node retrieval strengthen the need for a randomized trial to confirm the oncological safety of MIDP.

Splenopancreasectomia distale

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E-MIPS European consortium on Minimally Invasive Pancreatic Surgery

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Distal pancreatectomy, minimally invasive or open, for malignancy (DIPLOMA) – a randomized controlled trial

PROTOCOL SUMMARY:

Rationale: Several systematic reviews have suggested superior outcomes after minimally invasive distal pancreatectomy (MIDP) as compared to open distal pancreatectomy (ODP) for benign and pre-malignant disease. In the literature and in a recent pan-European survey, about one third of pancreatic surgeons expressed concerns specifically regarding the oncologic safety (i.e. radical resection, lymph node retrieval and survival) of MIDP in pancreatic cancer. Most surgeons stated that a randomised trial assessing oncologic safety in MIDP vs ODP for pancreatic cancer is needed.

Objective: To compare MIDP with ODP regarding radical resection rate for pancreatic ductal adenocarcinoma (PDAC) in the pancreatic body or tail.

Study design: A pan-European, randomised controlled, multicentre, patient-blinded non-inferiority trial. The protocol was designed according to the SPIRIT guidelines[1].

Events:

Geneva IHPBA 2018

13th IHPBA World Congress
September 3 - September 7

5th DIPLOMA trial meeting
September 3 - September 7

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E-MIPS

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name
Poliambulanza Institute Hospital Foundation

Dettagli da Google Maps

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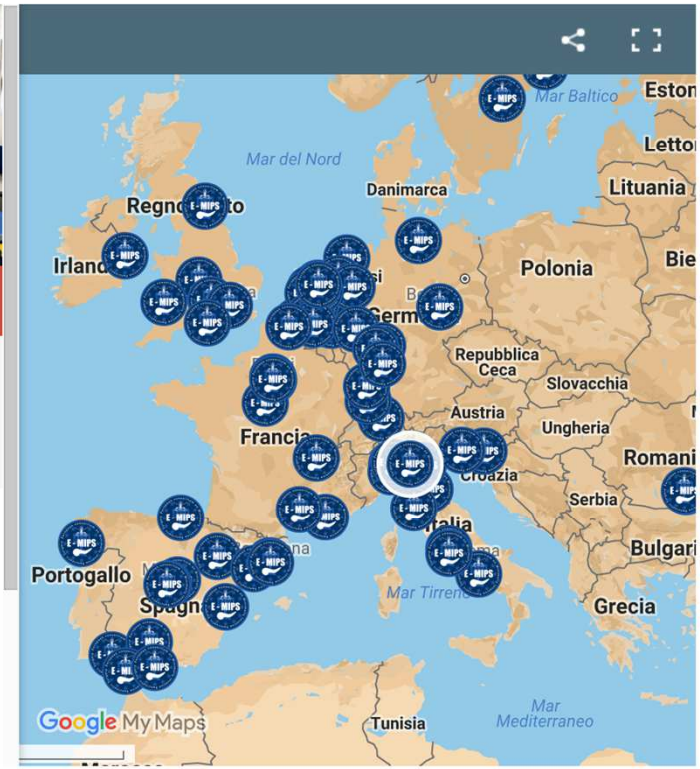
4.4 ★★★★½



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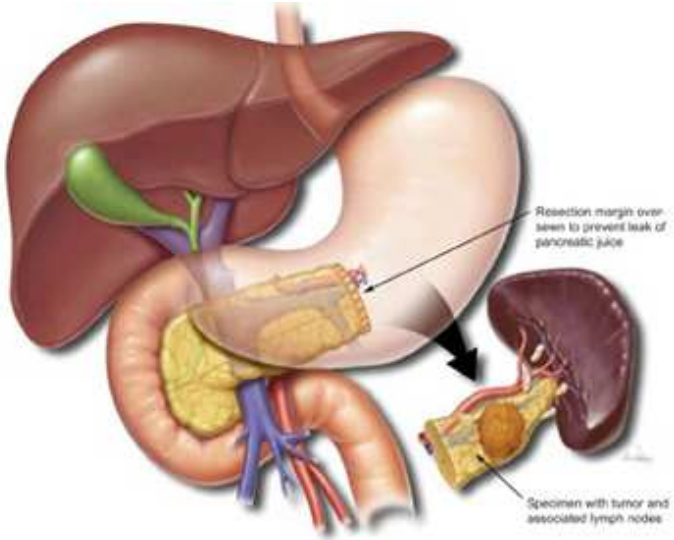
Splenopancreasectomia distale



- ✓ Intervento meno complesso della DCP ma a maggior rischio di fistola
- ✓ Splenectomia → protocolli vaccinali (haemophilus; meningococco; pneumococco; anti-influenzale)
- ✓ Nuova comparsa/peggioramento diabete
- ✓ Minor rischio di insufficienza pancreatica esocrina
- ✓ Diarree (RAMPS)

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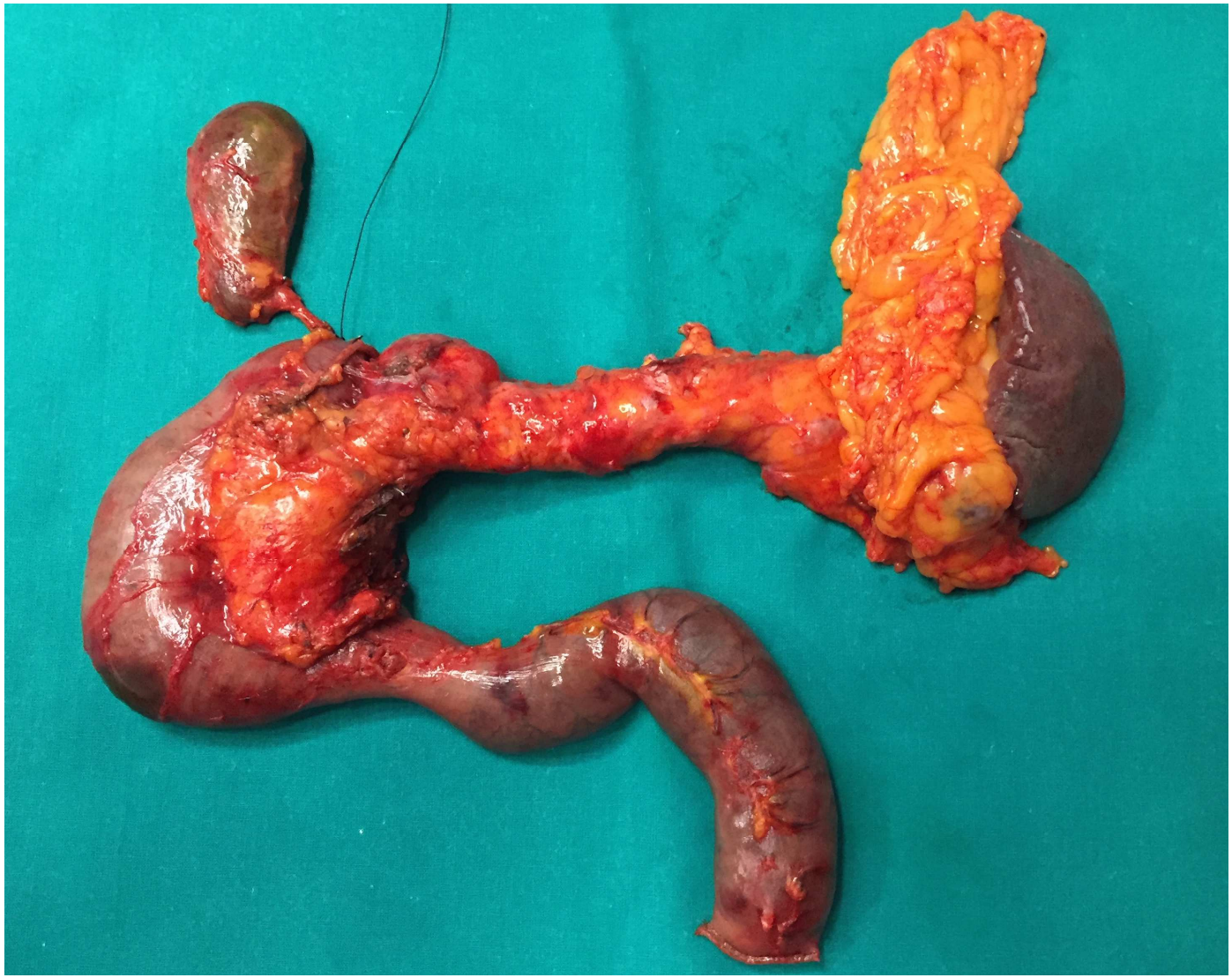
Pancreasectomia totale



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Pancreasectomia totale

- ✓ Presenza di malattia a livello della trancia pancreatica all'analisi intra-operatoria
- ✓ Resezioni vascolari arteriose

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Grazie per l'attenzione

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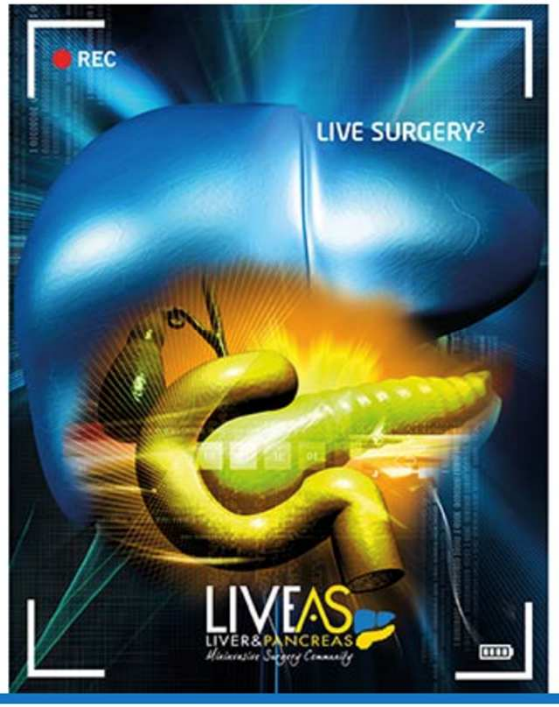
LIVEAS
LIVER&PANCREAS
Mininvasive Surgery Community

LIVE SURGERY²

6 JUNE 2018

10.00 am -3.00 pm CET



- Ultrasound guided laparoscopic liver resection
- Mini-invasive pancreatic resection for cancer

Click on **https://www.liveas.eu/register** for your registration! Remember your Log-in Information to get the Live Surgery Event!
#JoinTheCommunity

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Dr. Alessandro Ferrero
Chief of General and Oncological Surgery, Mauriziano Hospital Torino – Italy