

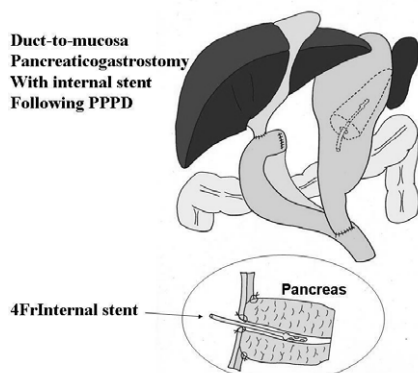
	N	Initial Los (days)	Readmissions (#)	Reoperations (#)	Total LOS (days)	Morbidity (%)
PERI	52	23.4±1.9	1.3±0.2	0.03±0.02	28.2±3.1	77
PANC	86	24.0±2.4	2.2±0.2*	0.58±0.17*	45.0±3.7	90*
		*p<0.05 vs PERI				

T1591

Duct-to-Mucosa Pancreaticogastrostomy with Internal Stent Following Pancreaticoduodenectomy Is a Safe Anastomosis: Diagnosed By the International Study Group Pancreatic Fistula (ISGPF) Definition

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Background and Objectives: Postoperative pancreatic fistula following pancreaticoduodenectomy is relatively common, and remains a major cause of severe complication and surgical mortality. The aim of this study was to evaluate the results of two-layered duct to mucosa pancreaticogastrostomy with internal stent as a method for restoring pancreaticoenteric continuity. **Methods:** From Dec. 2003 to Oct. 2008, prospectively collected data from 100 consecutive patients who underwent pancreaticoduodenectomy were evaluated. Postoperative pancreatic fistula was assessed using the criteria of International Study Group Pancreatic Fistula (ISGPF). **Results:** Median drain amylase on day 1 after surgery was 611 IU/L, on day 2 it was 255 IU/L, on day 3 it was 80 IU/L, and on day 5 it was 27 IU/L. Of 100 patients, 13 developed pancreatic fistula; grade A in 11 patients, grade B in 1, and grade C in 1. One re-do operations, but no postoperative percutaneous drainage, and no surgical mortality occurred. By univariate analysis, texture of the remnant pancreas was found to be significantly associated with ISGPF. However, all grade A pancreatic fistula occurred in the patient with soft remnant pancreas and the incidence of clinically significant PF (grade B, C) was 2% (one in soft and one in hard remnant pancreas), there was no significant clinical factor associated with clinically significant pancreatic fistula (ISGPF grade B,C). **Conclusions:** Two layered duct to mucosa pancreaticogastrostomy with internal stent for restoration of pancreaticoenteric continuity after pancreaticoduodenectomy is associated with a low incidence of clinically significant pancreatic fistula.



Duct-to-mucosa pancreaticogastrostomy with internal stent following PPPD

T1592

Clinicopathologic Features of Actual 5-Year Survivors After Macroscopic Curative Resection for Invasive Ductal Carcinoma of the Pancreas

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Background: Surgical resection for invasive ductal carcinoma of the pancreas is the only chance of cure, although the long-term prognosis might be poor with very few 5-year survivors. The current study aims to clarify the clinicopathologic features of actual 5-year survivors after macroscopic curative resection for invasive ductal carcinoma of the pancreas. **Methods:** Between January 1990 and December 2003, 242 patients, who underwent macroscopic curative pancreaticectomy for invasive ductal carcinoma of the pancreas and have been observed for more than 5 years from the time of resection, were enrolled in this study. All patients were histologically confirmed as a common type of pancreatic ductal adenocarcinoma. Invasive carcinoma originating in an intraductal papillary-mucinous tumor was included, because it has been classified as a subtype of invasive ductal carcinoma and clinically treated as the same entity. Data of patients who survived more than 5 years were analyzed retrospectively, and compared with those who died within 5 years. **Results:** There were 45 5-year survivors (18.6%), including 10 patients (4.1%) who survived greater than ten years. The median age of the patients (25 men and 20 women) was 63 years (range, 27-80 years). The distribution of the tumor stages according to the TNM classification (UICC 6th) was as follows: stage I (n = 4: 22%), II (n = 1: 6%), III (n = 5: 28%), IVA (n = 4: 22%), and IVB (n = 4: 22%). By multivariate analysis, pathological tumor category and lymph node status were the significant factor associated with 5-year survivors, with a hazard ratio (95% confidence interval) of 0.093 (0.016- 0.540: p=0.008) and of 0.218 (0.085- 0.561: p=0.002), respectively. Among the 45 5 year survivors, recurrence occurred in 9 patients (20%) from 0.4 to 5.3 years (median: 3.5 years) after operation. Seven patients died of disease from 5.0 to 7.3 (median: 5.8 years), while two patients are alive without disease 5.2 and 12.6 years after operation, respectively. **Conclusions:** Limited cancer extension with negative lymph node metastases significantly contributes a chance of surviving more than 5 years. However, macroscopic curative resection could provide a possibility of unpredictable

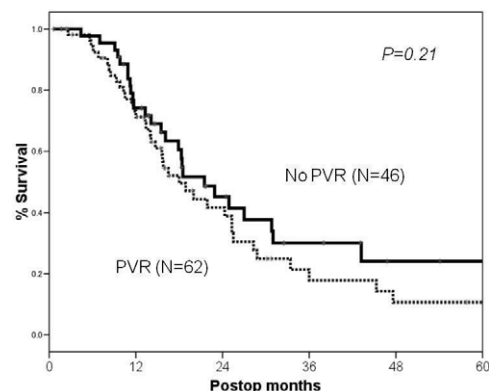
long-term survivors even with advanced stage. Five years survival does not always mean a cure of disease, but all of the recurrences occurred within 5.3 years after surgical resection.

T1593

Simultaneous Portal Venous Resection During Pancreatoduodenectomy for Locally Advanced Pancreas Head Cancer

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Background: Pancreatoduodenectomy (PD) provides only chance for cure in patients with pancreas head cancer (PHC). However, owing to tumor aggressive nature and its anatomical proximity we often encounter portal venous involvement at the time of diagnosis. It is still not clear how far we can go with surgery, i.e. the clinical impact of simultaneous portal venous resection (PVR) for PHC remains controversial. **Methods:** We reviewed our pancreas database of 108 patients with PHC who underwent PD during 2001-2007. Of 108 patients 62 (57%) underwent PVR. We compared the short and long-term outcome between patients with PVR (Group A) and those without PVR (Group B). **Results:** Age, gender and type of procedure (standard or pylorus-preserving PD) were not different between the groups. Tumor factor (T) was more advanced in Group A by JPS classification but not different by UICC classification because of definition. Nodal involvement was not different between the groups (75% vs. 63%). Of 62 patients with PVR 42 (68%) patients had pathologically-proven portal vein involvement. Mortality (30-day and all hospital death) was 2.7% and 6.5% respectively, and notably all mortality were seen in Group A. Morbidity were commonly seen in Group A but not statistically different (47% vs. 39%). Postoperative adjuvant chemotherapy was used in 82% and 83%, respectively. R0 resection was achieved in 65% in Group A and 74% in Group B (NS). Median survival time (MST) was 15.8 months in Group A and 21.5 months in Group B (P=.06). If mortality cases were excluded MST was 18.0 months in Group A (Figure). **Conclusion:** Simultaneous PVR during PD for patients with PHC provides similar clinical benefit as compared with those patients without having a PVR if surgical mortality is minimal. Further refinement of surgical technique is necessary but further improvement of survival cannot be achieved without more effective adjuvant therapy.



T1594

An Aggressive Approach to Pancreatoduodenectomy(PD)- Surgeon's Clinical Suspicion Matters

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Background: Despite advances in preoperative imaging and Histopathological techniques, the ability to accurately diagnose periampullary malignancy prior to PD remains a challenge. This paper examines the outcomes ability to accurately define malignancy in patients undergoing PD at a non university tertiary care center (NUTCC) **Methods:** Medical records of 122 patients, who underwent PD by a single surgeon between September 2005 to August 2008 at a high volume NUTCC, were analyzed. An attempt to establish preoperative diagnosis with endoscopy and/or endoscopic ultrasound was made in all patients with a final malignant diagnosis. The patients were managed by a multidisciplinary team consisting of a gastroenterologist, surgeon, hepatobiliary fellow, general surgery residents, ICU nursing staff, operating room team, and a surgery floor nursing staff. The records were reviewed with respect to preoperative and postoperative data, thirty-day mortality, morbidity and histopathology data. **Results:** Of the total 120 patients who underwent PD for resection of periampullary masses. 63% patients were found to have a diagnosis of periampullary carcinoma on final histopathology. Of these, 9% (7 patients) had a negative preoperative diagnosis for malignancy. All seven of these patients had significant comorbidities with 5 patients (70%) and 2 patients (30%) with ASA Class III and ASA class IV respectively. All seven of these patients were taken for PD based on the clinical suspicion. . Diagnosis of periampullary malignancy was confirmed intraoperatively, and on subsequent final histopathology. There was no mortality in any of the patients. Significant morbidity was seen in 2 patients. On final histopathology, all patients had negative margins, and 2 patients were node positive. 6 patients with suspicious preoperative histopathology, who had no evidence of malignancy on final histopathology, underwent PD. There was no mortality in any of these patients. Only one patient had significant comorbidity in the post operative period. The positive predictive value of preoperative histopathology was 0.92 whereas the negative predictive value was 0.84. **Conclusions:** PD is justified even in the presence of a negative preoperative histopathology at a NUTCC with results that meet reported outcomes and benchmarks. The evaluation of patients with potential periampullary masses requires a dedicated multidisciplinary team and aggressive surgery.