Extended pancreatectomy for pancreatic cancers

Sagar Sadhu · Manas Kr Roy

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Dear Sir,

We read with interest the excellent article by Shukla et al. (Extended pancreatectomy for pancreatic cancers. IJS 2009; 71:2–5). It is a ready-reckoner for the surgeon who is keen to update on the contextual importance of extended pancreatic resection. That extended lymphadenectomy doesn't confer survival advantage, is well proven in randomised trials and meta-analysis [1]. But what constitutes a R0 (complete resection) is still mired in confusion mainly because of lack of unanimity amongst pathologist on a standardized technique of histopathological examination [2]. Achieving negative resection margin is not only a surgical triumph, but could potentially increase survival. A randomized study from a center of repute showed a trend towards increasing survival in pancreatic cancer patients who had extended resection and this was attributed mainly due to higher incidence of negative resection margin in this sub-group [3]. In this respect the retroperitoneal resection margin, often termed as mesopancreas, is finding increasing prominence in the recent literature [4]. This structure extends from the posterior surface of the pancreatic head to behind the mesenteric vessels. In order to excise this tissue *en masse* the recently described hanging technique is an elegant operative innovation [5]. Briefly, the duodenum is widely Kocherized beyond the medial border of aorta and the origin of superior mesenteric artery (SMA) is identified. A

tunnel is dissected between the mesopancreas and the SMA and a tape is passed through. Sustained traction on this tape stretches the retroperitoneal margin, which is then excised in a controlled manner.

To some extent, the traditional nihilism surrounding portal vein invasion by pancreatic malignancy has been partially annulled by finding survival equivalence between patients who were operable vis-à-vis those who required portal vein excision for complete clearance. However, this benefit is limited to patients with superficial invasion into the tunica adventitia [6]. With deeper portal vein wall invasion into the tunica media or intima, the survival is similar to those with non-curative surgery. The depth of portal vein invasion appears to correlate with preoperative CT portogram type C and D and a tumor diameter more than 45 mm [6].

Although autologous venous and polytetrafluoroethylene grafts are conduits of choice for portal vein reconstruction, a generous Cattell-Braasch manoeuvre, wherein the ligament of Treitz is incised and hepatic flexure dissected liberally, serves to mobilise the root of mesentery and helps in moving it cranially. Mobilising the liver by incising the falciform, coronary and triangular ligaments causes a caudal displacement of the liver. These two steps in tandem approximate the transected ends of the portal vein and a defect as long as 5 cm could be primarily anastomosed in a tension free manner, thereby obviating the need for a graft [7].

S. Sadhu · M. K. Roy
Department of Surgery and MIS
Rabindranath Tagore International Institute of Cardiac Sciences,
124 Mukundapur, Kolkata, India

M. K. Roy (✉)
E-mail: manasroy66@yahoo.com

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