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Original article

Long-term Results of Pancreaticoduodenectomy with Superior Mesenteric and Portal Vein Resection for Ductal Adenocarcinoma in the Head of the Pancreas☆

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ABSTRACT

Introduction: The benefit of pancreaticoduodenectomy (PD) with superior mesenteric-portal vein resection (PVR) for pancreatic adenocarcinoma (PA) is still controversial in terms of morbidity, mortality and survival. We conducted a retrospective study to analyse outcomes of PD with PVR in a Spanish tertiary centre.

Methods: Between 2002 and 2012, 10 patients underwent PVR (PVR+ group) and 68 standard PD (PVR− group). Morbidity, mortality, overall survival (OS) and disease-free survival (DFS) were compared between PVR+ and PVR− group. Prognostic factors were identified by a Cox regression model.

Results: Postoperative mortality was 5% (4/78), all patients in PVR− group. Morbidity was higher in the PVR− group compared to PVR+ (63% vs 30%, *P*=.004). OS at 3 and 5 years was 43% and 43% in PVR+ group, 35% and 29% in PVR− group (*P*=.07). DFS at 3 and 5 years DFS were 28% and 15% in PVR+ group, 25% and 20% in PVR− group (*P*=.84). Median survival was 23.1 months in PVR− group, and 22.8 months in PVR+ group (*P*=.73). Factors related with OS were absence of adjuvant treatment (OR 2.9, 95%IC: 1.39–6.14, *P*=.003), R1 resection (OR 2.3, 95%IC: 1.2–4.43, *P*=.006), preoperative CA 19.9 level ≥ 170 UI/mL (OR 2.3, 95%IC: 1.22–4.32, *P*=.01). DFS risk factors were R1 resection (OR 2.6, 95%IC: 1.41–4.95, *P*=.002); moderate or poor tumour differentiation grade (OR 2.7, 95%IC: 1.23–6.17, *P*=.01); N1 lymph node status (OR 1.8, 95%IC: 1.02–3.19, *P*=.04); CA 19.9 level ≥ 170 UI/mL (OR 2.4, 95%IC: 1.30–4.54, *P*=.005).

Conclusions: PVR for PA can be performed safely. Patients with PVR have a comparable survival to patients undergoing standard PD if disease-free margins can be obtained.

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Resultados a largo plazo de la duodenopancreatectomía cefálica con resección de la vena mesentérica superior y vena porta por adenocarcinoma de la cabeza de páncreas

Palabras clave:
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R E S U M E N

Introducción: El beneficio de la duodenopancreatectomía cefálica (DPC) con resección de la vena mesentérica superior/vena porta (RVP) para el adenocarcinoma de páncreas (ADCP) es controvertido en cuanto a la morbilidad, mortalidad y supervivencia. Se analizan los resultados de la DPC con RVP en un centro terciario español.

Métodos: Entre 2002 y 2012, 10 pacientes fueron tratados mediante RVP (RVP+) y 68 con DPC estándar (RVP−). La morbilidad, mortalidad, supervivencia global (SG) y supervivencia libre de enfermedad (SLE) se compararon entre pacientes RVP+/RVP−. Los factores pronósticos fueron identificados con regresión de Cox.

Resultados: La mortalidad postoperatoria fue del 5% (4/78), todos los pacientes en el grupo RVP−. La morbilidad fue mayor en el grupo RVP− comparado con RVP+ (63 vs. 30%; p = 0,04). La SG a 3 y 5 años fue 43 y 43% en el grupo RVP+, 35 y 29% en RVP− (p = 0,7). La SLE a 3 y 5 años fue 28 y 15% en RVP+, 25 y 20% en RVP− (p = 0,84). La mediana de supervivencia fue de 23,1 meses en el grupo RVP− y de 22,8 meses en el grupo RVP+ (p = 0,73). Los factores relacionados con la SG fueron ausencia de tratamiento adyuvante (OR 2,9; IC95%: 1,39-6,14; p = 0,003), resección R1 (OR 2,3; IC95%: 1,2-4,43; p = 0,006), CA 19.9 ≥ 170 UI/mL (OR 2,3; IC95%: 1,22-4,32; p = 0,01). Los factores de riesgo para SLE fueron resección R1 (OR 2,6; IC95%: 1,41-4,95; p = 0,002); tumores pobremente diferenciados (OR 2,7; IC95%: 1,23-6,17; p = 0,01); tumores N1 (OR 1,8; IC95%: 1,02-3,19; p = 0,04); CA 19.9 ≥ 170 UI/mL (OR 2,4; IC95%: 1,30-4,54; p = 0,005).

Conclusiones: La RVP para ADCP puede realizarse con seguridad. Pacientes con RVP tienen una supervivencia comparable a los pacientes tratados mediante DPC estándar si se obtienen márgenes libres.

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Introduction

A ductal adenocarcinoma of the pancreatic head (DAPH) is the fourth cause of death due to cancer in Spain, with approximately 4000 new cases diagnosed every year.[1] Cephalic duodenopancreatectomy (CDP) for DAPH is the only potentially curative treatment for this type of aggressive cancer. However, only 10%–20% of these patients are treated with surgery. This is mainly due to the presence of metastatic disease or locally advanced in the form of vascular invasion at the time of the diagnosis.[2,3] The long-term results after surgery are still poor, with a global survival at 5 years between 10% and 27%, and with a mean survival between 14 and 33 months in the most recent papers, even with adjuvant or neoadjuvant chemoradiotherapy (NCRT).[4–9] Multimodal onco-surgical therapy has increased the resectability rate, particularly for patients with DAPH classified as *borderline*.[10] An extension of the retroperitoneal tumour usually implies the invasion of the superior mesenteric vein/portal vein (SMV/PV), which, in that case, has to be resected to achieve complete excision (R0), and allow cure.[11,12] The long-term survival results of the CDP with venous resection seem, at least, comparable to those of the patients without vascular resection, but the effective benefit of this procedure is still being discussed.[13–17]

The purpose of this study is to analyse the results of CDP with SMV/PV resection, compared with CDP without venous resection, in a European university hospital.

Methods

Selection of Patients

Between 2002 and 2012, 252 patients were treated with CDP in our centre. The patient data was registered prospectively in a database. Patients that required pancreatic resection due to a benign disease, with periampullary cancer, distal bile duct cholangiocarcinoma, neuroendocrine tumours and intraductal mucinous papillary neoplasm were excluded. A retrospective analysis was performed on 78 CDPs with curative intent for DAPH: 10 patients with SMV/PV resection (PVR+) were compared to 68 patients without venous resection (PVR−). The data registered were: demographic, surgical and pathology data, complications, hospital stay, global survival (GS) and disease-free survival (DFS). The mean follow-up time was 23 months (range: 1–132). The preoperative assessment of the patients consisted of a detailed medical history and a physical exam, CA19-9 levels and a thoracoabdominal computed tomography (CT scan). Magnetic resonance cholangiopancreatography, endoscopic retrograde cholangiopancreatography

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