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Press review

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■ Long-term surveillance is best in patients with cystic lesions of the pancreas

Lawrence SA, Attiyeh MA, Seier K, et al. Should patients with cystic lesions of the pancreas undergo long-term radiographic surveillance? Results of 3024 patients evaluated at a single institution. *Ann Surg* 2017;266:536–44.

Objective

In 2015, the American Gastroenterological Association recommended the discontinuation of radiographic surveillance after 5 years for patients with stable pancreatic cysts. The current study evaluated the yield of continued surveillance of pancreatic cysts up to and after 5 years of follow-up.

Methods

A prospectively maintained registry of patients evaluated for pancreatic cysts was queried (1995–2016). Patients who initially underwent radiographic surveillance were divided into those with < 5 years and ≥ 5 years of follow-up. Analyses for the presence of cyst growth (> 5 mm increase in diameter), cross-over to resection, and development of carcinoma were performed.

Results

A total of 3024 patients were identified, with 2472 (82%) undergoing initial surveillance. The ≥ 5-year group ($n = 596$) experienced a greater frequency of cyst growth (44% vs. 20%; $P < 0.0001$), a lower rate of crossover to resection (8% vs. 11%; $P = 0.02$), and a similar frequency of progression to carcinoma (2% vs. 3%; $P = 0.07$) compared with the < 5-year group ($n = 1876$). Within the ≥ 5-year group, 412 patients (69%) had demonstrated radiographic stability at the 5-year time point. This subgroup, when compared with the < 5-year

group, experienced similar rates of cyst growth (19% vs. 20%; $P = 0.95$) and lower rates of crossover to resection (5% vs. 11%; $P < 0.0001$) and development of carcinoma (1% vs. 3%; $P = 0.008$). The observed rate of developing cancer in the group that was stable at the 5-year time point was 31.3 per 100,000 per year, whereas the expected national age-adjusted incidence rate for this same group was 7.04 per 100,000 per year.

Conclusion

Cyst size stability at the 5-year time point did not preclude future growth, cross-over to resection, or carcinoma development. Patients who were stable at 5 years had a nearly 3-fold higher risk of developing cancer compared with the general population and should continue long-term surveillance.

Comments

1. This is a retrospective study using a prospectively-maintained data base, with a large number of patients, but covering a long period of time, more than 20 years. Consequently, the patient groups were not homogeneous, they did not have the same radiological follow-up, if not only because of progress accomplished in imaging.
2. The reasons to discontinue surveillance before the 5-year cut-off were not clearly explained. Was it because surgery was performed, or because of patient wishes? Cyst growth was seen in 25% of patients during surveillance leading to resection in 11% (262 patients overall, 214 in the group followed for less than 5 years).
3. These data render the message of this study abstruse. The question was to know whether surveillance for more than 5 years was necessary when cyst size was stable. Four hundred and twelve patients corresponded to this criterion. Of these, 20 (5%) had a resection and cancer was diagnosed in four (1%), a rate that is described as greater than that in the overall population and therefore this would justify continued surveillance.

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4. Moreover, the authors included in their analysis all cystic lesions of the pancreas, but most were IPMN on pathology reports of resections. The conclusions concerning surveillance for longer than 5 years are therefore largely based on cases that proved to be IPMN. This is in agreement with the recent recommendations of the international Fukuoka consensus [1]: surveillance of IPMN is recommended as long as the patient is fit for surgery. Surveillance should rely on CT scan, magnetic resonance and endoscopic ultrasound, performed alternately.
5. Some of the "worrisome" criteria that can be seen on imaging are important to underscore: (1) size > 3 cm; (2) contrast-enhanced mural nodule < 5 mm; (3) thick walls, enhanced by contrast; (4) main pancreatic duct diameter between 5-9 mm; (5) main pancreatic duct stricture with pancreatic atrophy; (6) lymphadenopathy; (7) elevation of serum CA 19-9; (8) increase in cyst diameter > 5 mm/2 years. In presence of these criteria, it is necessary to complete patient workup including endoscopic ultrasound and to propose surgery in cases where the parietal nodule is > 5 mm, there is suspicion of main pancreatic duct involvement, or positive or borderline cytology. In the absence of these criteria, a cyst diameter > 3 cm in a young person should also lead to entertain surgical resection.

Reference

[1] Pancreatology 2017.

■ No need to drain distal pancreatectomies routinely according to this multicenter randomized trial

Van Buren G, Bloomston M, Schmidt CR, et al. A prospective randomized multicenter trial of distal pancreatectomy with and without routine intraperitoneal drainage (NCT01441492). *Ann Surg* 2017;266:421–31.

Objective

The objective of this study was to test the hypothesis that distal pancreatectomy (DP) without intraperitoneal drainage does not affect the frequency of grade 2 or higher-grade complications.

Background

The use of routine intraperitoneal drains during DP is controversial. Prior to this study, no prospective trial focusing on DP without intraperitoneal drainage has been reported.

Methods

Patients undergoing DP for all causes at 14 high-volume pancreas centers were preoperatively randomized to placement of a drain or no drain. Complications and their severity were tracked for 60 days and mortality for 90 days. The study was powered to detect a 15% positive or negative difference in the rate of grade 2 or higher-grade complications. All data were collected prospectively and source documents were reviewed at the coordinating center to confirm completeness and accuracy.

Results

A total of 344 patients underwent DP with ($n=174$) and without ($n=170$) the use of intraperitoneal drainage. There were no differences between cohorts in demographics, comorbidities, pathology, pancreatic duct size, pancreas texture, or operative technique. There was no difference in the rate of grade 2 or higher-grade complications (44% vs. 42%, $P=0.80$). There was no difference in clinically relevant postoperative pancreatic fistula (18% vs 12%, $P=0.11$) or

mortality (0% vs 1%, $P=0.24$). DP without routine intraperitoneal drainage was associated with a higher incidence of intra-abdominal fluid collection (9% vs 22%, $P=0.0004$). There was no difference in the frequency of postoperative imaging, percutaneous drain placement, reoperation, readmission, or quality of life scores.

Conclusions

This prospective randomized multicenter trial provides evidence that clinical outcomes are comparable in DP with or without intraperitoneal drainage.

Comments

1. This is the fourth randomized study evaluating the value of routine abdominal drainage after pancreatectomy, but the first that targets distal pancreatectomy alone, as the others included essentially patients undergoing pancreatoduodenectomies. For two of these studies, routine drainage did not offer any benefit [1,2] while in the last, the authors reported increased mortality when the drain was omitted [3].
2. Initially, the study was meant to include both pancreatoduodenectomy and distal pancreatectomy but the study was stopped prematurely in 2012 because of increased mortality in the non-drain group [3]. The study was then modified, targeting only distal pancreatectomies, because of the potential lesser severity of postoperative pancreatic fistula (POPF) occurring after distal pancreatectomy due to the absence of gastro-intestinal contamination or biliary anastomosis. This might also explain why the inclusion period was long, more than 5 years.
3. The methodology and the quality control of this study were excellent. Randomization was preoperative, and there was only one protocol violation (one non-drain patient was drained). The two groups were well balanced with regard to pancreatic texture, the method of stump closure (71% stapled), body mass index, and the rate of associated complementary surgical gestures (25%).
4. Only expert centers (more than 50 pancreatic resection per year) participated in this study, which might represent a bias. To the question of whether the rate of postoperative complications would be the same in small volume centers, Van Buren answered that routine prophylactic drainage might be indicated in two situations: in centers where interventional radiologists were not available 24/7 and when the patient could not be carefully monitored during the 2 weeks after surgery.
5. The prescription of somatostatin analogues was left to the discretion of the surgeon. The choice of the type of drain was also left to the surgeon. However, it is somewhat disappointing that these data were not collected prospectively.
6. The question that remains is whether there is a specific group of patients that are at higher risk of developing a POPF who might benefit from prophylactic drainage. Currently, there is no score that allows calculation of this risk. Therefore, no recommendation can be made.
7. Of note, when the surgeon decides to insert a drain, it is possible to remove it on postoperative day 3 in patients with a low risk of POPF (drain amylase ≤ 5000 UI/L on day 1) [4].

References

- [1] *Ann Surg* 2001;234:487–93.
- [2] *Ann Surg* 2016;264:528–37.
- [3] *Ann Surg* 2014;259:605–12.
- [4] *Ann Surg* 2010;252:207–14.

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