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Original article

Initial Experience in the Treatment of "Borderline Resectable" Pancreatic Adenocarcinoma☆

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ABSTRACT

Introduction: A borderline resectable group (APBR) has recently been defined in adenocarcinoma of the pancreas. The objective of the study is to evaluate the results in the surgical treatment after neoadjuvancy of the APBR.

Method: Between 2010 and 2014, we included patients with APBR in a neoadjuvant and surgery protocol, staged by multidetector computed tomography (MDCT). Treatment with chemotherapy was based on gemcitabine and oxaliplatin. Subsequently, MDCT was performed to rule out progression, and 5-FU infusion and concomitant radiotherapy were given. MDCT and resection were performed in absence of progression. A descriptive statistical study was performed, dividing the series into: surgery group (GR group) and progression group (PROG group).

Results: We indicated neoadjuvant treatment to 22 patients, 11 of them were operated, 9 pancreatoduodenectomies, and 2 distal pancreatectomies. Of the 11 patients, 7 required some type of vascular resection; 5 venous resections, one arterial and one both. No postoperative mortality was recorded, 7 (63%) had any complications, and 4 were reoperated. The median postoperative stay was 17 (7–75) days. The pathological study showed complete response (ypT0) in 27%, and free microscopic margins (R0) in 63%. At study clossure, all patients had died, with a median actuarial survival of 13 months (9.6–16.3). The median actuarial survival of the GR group was higher than the PROG group (25 vs 9 months; $P<.0001$).

Conclusion: The neoadjuvant treatment of APBR allows us to select a group of patients in whom resection achieves a longer survival to the group in which progression is observed. Post-adjuvant pancreatic resection requires vascular resection in most cases.

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Experiencia inicial en el tratamiento del adenocarcinoma de páncreas *borderline resectable*

R E S U M E N

Introducción: Se ha definido un grupo de resecabilidad *borderline resectable* (APBR) en el adenocarcinoma de páncreas. El objetivo del estudio es evaluar los resultados en el tratamiento quirúrgico tras neoadyuvancia del APBR.

Método: Entre 2010 y 2014 incluimos pacientes afectos de APBR en un protocolo de neoadyuvancia y cirugía, estadificados mediante tomografía computarizada multidetector (TCMD). El tratamiento con quimioterapia se basó en gemcitabina y oxaliplatino (GEMOX). Posteriormente, se realizó TCMD para descartar progresión, y se administró 5-FU en infusión y radioterapia concomitante. Se practicó TCMD y resección en ausencia de progresión. Se realizó un estudio estadístico descriptivo, dividiendo la serie en grupo resección (grupo GR) y grupo progresión (grupo PROG). El seguimiento finalizó en febrero de 2016.

Resultados: Indicamos tratamiento neoadyuvante a 22 pacientes, 11 de ellos fueron finalmente intervenidos. Se realizaron 9 duodenopancreatectomías cefálicas, una duodenopancreatectomía total y una pancreatectomía corporocaudal. De los 11 pacientes, 7 requirieron algún tipo de resección vascular; 5 resecciones venosas, uno arterial y otro ambas. No hubo mortalidad postoperatoria, 7 (63%) tuvieron alguna complicación y 4 fueron reintervenidos. La estancia hospitalaria postoperatoria mediana fue 17 días (7-75). El estudio patológico evidenció márgenes microscópicos libres (R0) en el 63% de los pacientes y ausencia de afectación adenopática en 10 pacientes (ypN0). Al cierre del estudio, todos los pacientes habían fallecido, con una supervivencia actuarial mediana de 13 meses (9,6-16,3). La supervivencia actuarial mediana del grupo GR fue superior al grupo PROG (25 vs 9 meses; $p < 0,0001$).

Conclusión: El tratamiento neoadyuvante del APBR permite seleccionar un grupo de pacientes en el que la resección consigue una supervivencia superior al grupo en el que se observa progresión. La resección pancreática posneoadyuvancia requiere resecciones vasculares en la mayoría de los casos.

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Palabras clave:
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Introduction

The term ''borderline-resectable pancreatic cancer'' (BRPC) describes a borderline resectability concept first used by Maurer in 1999.[1] This concept was introduced to classify tumors that are between resectable and unresectable tumors.[2] The definition is based on the findings of multidetector computed tomography (MDCT). In 2006, the MD Anderson[3] group published a classification that included BRPC. Three groups were defined according to vascular involvement: resectable tumors, borderline-resectable tumors, and unresectable tumors. The borderline-resectable group included patients with borderline resectability, whose tumors could be resected after neoadjuvant therapy. The authors have published good post-resection results in BRPC patients after neoadjuvant treatment, especially considering that in the past they were considered unresectable tumors. Recently, this classification has been adopted in an international consensus, with minimal changes.[4] The aim of this study is to review the short- and medium-term results obtained at our hospital for the surgical treatment of BRPC after neoadjuvant therapy, and to analyze morbidity and mortality after post-neoadjuvant therapy surgery.

Material and Methods

We have collected data from the experience in the surgical treatment of BRPC after neoadjuvant therapy from July 2010 to November 2014 at the Hospital Universitari de Bellvitge and the Servei d'Oncologia Mèdica at Institut Català d'Oncologia in L'Hospitalet, Spain. We prospectively registered data for patient demographics, neoadjuvant regimen, surgery performed, anatomic pathology results and the follow-up period of all patients. The patient follow-up was finalized in February 2016.

Staging Study

A 64-MDCT was used for diagnosis and staging. Patients were classified according to criteria published by the MD Anderson Group[3] as having resectable, borderline-resectable or unresectable tumors. BRPC was defined as tumors of the head of the pancreas in contact with the superior mesenteric artery (SMA) of less than 180°, obliteration of the portal vein/superior mesenteric vein (PV/SMV) with the possibility of reconstruction, and/or contact with the hepatic artery at its union with the gastroduodenal artery. We have also included lesions in

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