BP SY 1-3

Reappraisal of total pancreatectomy in the era of neoadjuvant therapy

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Lecture :

[Background]

Total pancreatectomy (TP) has initially been reported in the 1940s for the radical treatment of chronic pancreatitis [1]. Due to the historically high surgical morbidity as well as mortality, a widespread use has not occurred within the following decades. Furthermore, the unavoidable consequence of insulin dependency has prevented wide acceptance.

[Current Situation]

Since the early 2000s, TP has seen a revival, not only for therapy of chronic pancreatitis but especially in pancreatic cancer (PDAC) surgery [2]. This can be attributed to a continuous improvement of surgical techniques and complication management as well as the improvements in care for exocrine and endocrine consequences of this radical operation [3, 4]. Besides standard TP, also extended approaches have been increasingly reported and TP can today be categorized in a four-tier classification, including standard TP, TP with venous resection, TP with additional organ resection and TP with arterial resection [5]. Another important aspect is the increasing use of neoadjuvant therapy for borderline resectable and locally advanced PDAC, which allows to increase the number of patients who qualify for (also extended) PDAC surgery including TP without compromising oncological results [6].

[Future Perspective]

On one hand, with the upcoming aim of personalizing PDAC therapy and potential new prognostic markers, TP can be expected to be a solid and widely accepted surgical component for respectively selected patients who can benefit from this approach due to a favourable tumour biology. On the other hand, it can be expected that TP – such as other pancreatic resections – will be increasingly performed minimally-invasive and especially robotically in the future [7]. In addition, further evidence on short- and long-term outcomes will be generated to allow a better evaluation of the true value of such innovative surgical procedures.

[References]

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