## Symposium V

# Treatment of Small Ampullary Tumor - Surgical Treatment

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### Introduction

Ampullary tumors are relatively uncommon and account for about 6% of all periampullary tumours. The prognosis of ampullary carcinoma is better than that for pancreatic adenocarcinoma, and the 5-year survival is between 20% and 60%.<sup>1</sup>

The first documented resection of an ampullary tumour was performed by Halstead in 1898. Unfortunately the patient died after 7 months from tumour recurrence.<sup>2</sup>

Adenomas, especially villous adenomas, are known to be premalignant. Familial adenomatous polyposis is associated with an increased risk for developing periampullary adenomas and carcinomas.<sup>3</sup> This usually happens one to two decades after the associated colon cancers. Other possible but not well-established risk factors include cholecystectomy, sphincterotomy and tobacco.

#### Discussion

## 1. Surgery

Management depends on the stage of the tumour and the condition of the patient. Very elderly and frail patients who are not considered suitable for surgical exploration are often well palliated by endoscopic stenting, or even simply by sphincterotomy, which may have to be repeated. For patients fit for surgery, resection offers a significantly higher cure rate than that for cancer of the head of pancreas and also excellent palliation. The choice lies between local excision and pancreato-duodenectomy.

In patients with very small tumours, local excision may be curative, but pancreato-duodenectomy is the procedure of choice. Transduodenal radical excision of a bulky ampullary cancer may, in fact, be more hazardous than resection of the head of pancreas because of the risks of pancreatitis and duodenal or pancreatic fistula formation. Pylorus preserving pancreato-duodenectomy<sup>4</sup> may be particularly applicable to these tumours. Fear that this procedure would compromise radicality has not been borne out by experience.<sup>5,6</sup>

Patients unsuitable for resection can be treated by palliative bypass (hepatico-jejunostomy) though this leaves the potential problems of future bleeding or gastric outlet obstruction. In a randomised trial, Lillemoe and colleagues found that performing a prophylactic gastro-jejunostomy prevented the development of gastric outlet obstruction, which subsequently occurred in 19% of the control group. There was no difference in morbidity between the two group.<sup>7</sup>

## 2. Adjuvant therapy

There is no good evidence regarding the role of chemotherapy or radiotherapy in surgically resected ampullary cancers. However, some authors believe that chemoradiation may be beneficial in patients with bad prognostic signs.<sup>8</sup> Studies of unresected tumours generally include both ampullary and pancreatic cancers, so conclusions are impossible for this tumour type.

### Conclusions

The overall 5-year survival rates reported for radical resection and for local excision are rather similar, ranging from 25 to 55%. In a series of 123 patients with ampullary carcinoma, the median survival in resected patients was 58.8 months (46% 5-year survival) versus 9.7 months in unresected patients (0% 5-year survival). The operative mortality rate was 5%.<sup>9</sup>

## References

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