Symposium 1 (Debate): Take it Out or Not

1. Pancreatic cancer with isolated PV/SMV invasion
1) con

Department of Surgery, Yonsei University College of Medicine, Korea

Chang Moo Kang

Pancreatic cancer may be systemic disease. Most patients are found in advanced stage of disease, and only about 15% of the patients can receive resection of the cancer. Till now, margin-negative resection is regarded as most effective treatment modality; however, most patients usually experience cancer recurrence, especially in liver, within 2 years after surgery, ultimately leading to cancer mortality. Overall 5-year survival of the pancreatic cancer is 5%, and 5-year-survial in patients who underwent surgery is about 15-20%, suggesting most pancreatic cancer that can be observed in our clinical practice is surely systemic disease. Therefore, postoperative adjuvant treatment should be mandatory after margin-negative resection. Unfortunately, about 30-50% patients are reported not to receive adjuvant treatment following surgery due to delayed recovery and severe complication form 'pancreatectomy'.

With advance of surgical techniques and perioperative management, pancreaticoduodenectomy with or without venous vascular resection is safe and standard procedure, but, it can be associated with high morbidity. In addition, taking surgical anatomy and tumor biology into consideration, the anatomically resectable pancreatic cancer can result in margin-positive resection. It is true that pancreatic cancer with isolated venous vascular invasion is technically RESECTABLE disease, however, oncologic point of views suggest that pancreatic cancer may be systemic disease. In this point, pancreatic surgeons should focus on *pancreatectomy with high oncologic efficacy*. Our goal should not be *technical* resection, but be *oncological* resection. Why do we avoid resection in case of technically resectablepancreatic cancers with liver metastasis? Why do we let the patients take PET-CT before surgery in pancreatic cancer? That's because surgeons need to select the proper patients who will take great advantages of PANCREATECTOMY in treating pancreatic cancer. That's because surgeons want to increase oncologic efficacy of pancreatectomy in pancreatic cancer patients. Considering potential benefit of neoadjuvnat chemo±radiation therapy, neoadjuvnat approachmay be currently available primitive form of patients-oriented [tailored] surgical approach in treating pancreatic cancer. It provides 1) the chance for selecting patients, 2) potential therapeutic effect, and 3) completion of systemic treatment in managing pancreatic cancer. In near future, more delicate andeffective neoadjuvant modality should be introduced.

Reference

1. Cho IR, et al. Gemcitabine based neoadjuvnat chemoradiation therapy in patients with borderline resectable pancreatic cancer. Pancreatology 2013;6:539-43.
2. Kang CM, et al. Controversial issues of neoadjuvant treatment in borderline resectable pancreatic cancer. Surg Oncol 2013;22:123-31.
3. Kang CM, et al. Potential contribution of preoperative neoadjuvant concurrent chemoradiation therapy on margin-negative resection in borderline resectable pancreatic cancer. J Gastrointest Surg 2012;16:509-17.
4. Kelly KJ, et al Vein Involvement During Pancreaticoduodenectomy: Is there a need for redefinition of borderline resectable disease? J Gastrointest Surg 2013;17:1209-17.
5. Ouaissi M, et al, Vascular reconstruction during pancreatectomy for ductal adenocarcinoma of the pancreas improves resectability but does not achieve cure. World J Surg 2010;34:2648-61.

1. Pancreatic cancer with isolated PV/SMV invasion
2) pro

Department of Surgery, University of Ulsan College of Medicine, Korea

Song-Cheol Kim

췌장암은 많은 경우 혈관 침범을 동반한다. 특히 많은 경우 PV/SMV를 침범한다. PV/SMV의 침범에 대하여는 AJCC에서도 전에는 stage III로 inpoerable로 정의 했으나 최근 resection을 권유하며 stage II로 올려놓았다. NCCN guideline이나 MD anderson같은 병원도 PV/SMV를 적극적으로 절제하는 것을 권유하고 있다. 하지만 많은 보고는 이에 대한 논쟁이 있는 것이 사실이다. 최근의 한 보고는 혈관 절제시 높은 합병증을 보고 하였으며 본원의 성적도 좋지 않은 실정이다. 하지만 절제하지 않았을 경우 상당한 예에서 진행과 더불어 좋지 않은 예후를 보여 절제를 결정하기가 쉽지 않은 상태이다. 이에 본 발표에서는 이에 대한 장, 단점에 대해 논의하기로 한다.

2. Small neuroendocrine tumor of the pancreas
1) con

Department of Gastroenterology, Seoul National University College of Medicine, Korea

Jin-Hyeok Hwang

Pancreatic neuroendocrine tumors (pNETs), also known as islet cell tumors, are rare neoplasms that arise in the endocrine tissues of the pancreas. Pancreatic NETs are only 1% to 3% of all pancreatic neoplasms [1]. However, these tumors have been gaining more attention recently, with a 2 to 3-fold increase in incidence for the past decades. According to the Surveillance, Epidemiology, and End Results (SEER) in United States, the age-adjusted annual incidence per 100,000 increased from 0.16 and 0.20 in 1973-1975 to 0.20 and 0.38 in 1996-2000 in female and males, respectively [2.3]. More recently, Japanese study in 2005 showed that an annual incidence was 1.01/100,000 that was approximately three times compared with that of the United States [4]. It could be explained that more people have a regular medical checkup and the resolution of diagnostic imaging tools has been highly improved.

Most pancreatic neuroendocrine tumors (pNETs) have been known to display an indolent course with longer survival compared with pancreatic adenocarcinoma [5]. However, theyhave malignant potential in 5-15% of insulinomas and 50-90% of the other pNETs including gastrinoma, glucagnoma, VIPoma, and nonfunctioning pNETs [6]. Although complete resection of the tumors is mandatory in spite of a substantial morbidity and measurable mortality of pancreatectomy, it is still unclear whether incidentally discovered, sporadic nonfunctioning (NF)-pNETs should be removed if they are small-sized tumors, because morbidity of pancreatectomy is still very high even in high-volume facilities. Therefore, when clinicians face the patients who have incidentally found small NF-pNETs, it would be somewhat hard to make a decision to perform resection immediately. Recently, with the wide use of high-quality cross-sectional imaging the incidental detection of small NF-pNETs has been increasing, whereas their natural history is largely unknown. Therefore, small NF-pNETs without symptoms has become a debating issue regarding to the treatment strategies [7]. New concept in this issue is needed to avoid surgery in carefully selective patients in order to evade morbidity and unnecessary surgery. This concept of selective surgery to incidentally found small NF-pNETs is very familiar to management of adrenal incidentaloma.

According to the data from the Massachusetts General Hospital [5], the mean tumor diameter of NF-pNETs decreased in the last decades (1988 to 1999 being 5.6cm and 2000 to 2005 being 4.1cm).