can be interpreted in some cases of tumor and tumor differentiating from focal inflammation.

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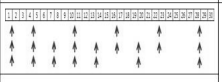
Panel Discussion: Case presentation

Department of Surgery, Seoul National University College of Medicine, Korea
(서울대학교 의과대학 외과학교실)

Mee Joo Kang
(강미주)

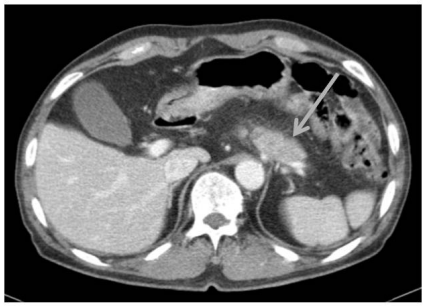
Pancreas cancer work up in Korea

- **Survey of major 7 centers**

	Preop		Postop		
	Routine	Prn	F/U	Interval	Main F/U
CT	7		7		IM (2) GS (3) Both(2) <Test order> IM (1) GS (4)
MRI	4	2			
PET	5	2 (Routine in IM without request from GS)	3	1/year vs. prn	
EUS	1	5 (Routine in IM without request from GS)			
EUS/ERCP biopsy	1	5 (Routine in IM without request from GS)			

INDETERMINATE PANCREATIC LESION

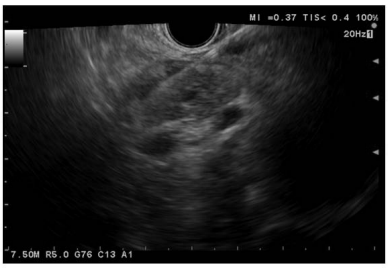
CT



R/O pancreatic cancer, R/O autoimmune pancreatitis

→ **What can we do?**

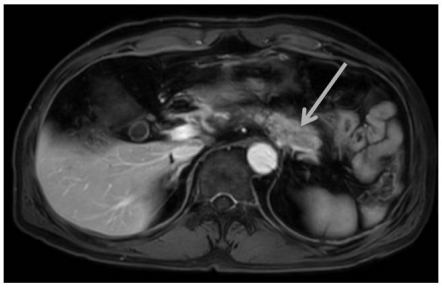
EUS-guided biopsy



Non-neoplastic pancreatic parenchyme with inflammatory cell infiltration

→ **Can we conclude that it is not cancer?**

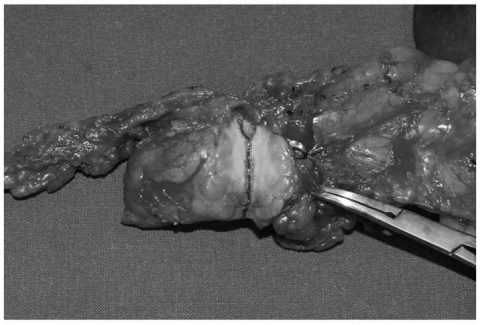
MRI



R/O pancreatic cancer, R/O autoimmune pancreatitis

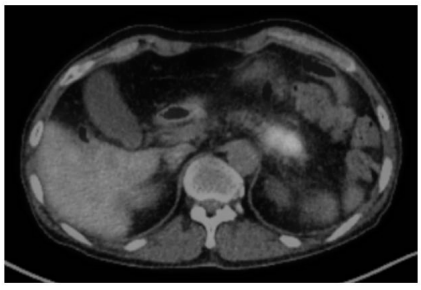
→ **Next step?**

Distal pancreatectomy



Ductal adenocarcinoma pT3N0, negative margin

PET



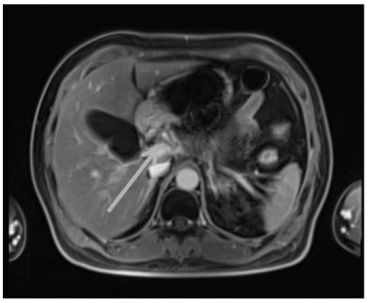
R/O inflammation

→ **How can we conclude the results?**

- **Which exam is most reliable to diagnose pancreatic cancer?**
- **When should we perform EUS guided biopsy?**
- **Is the biopsy result of EUS conclusive?**
- **Should we operate on indeterminate lesions of the pancreas?**

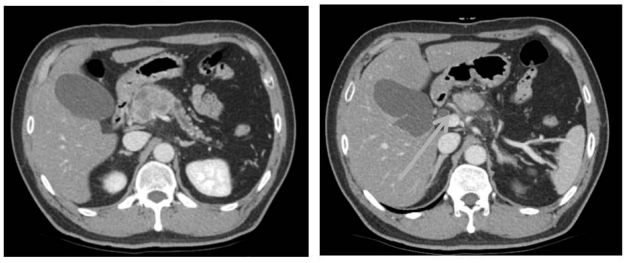
EVALUATION OF TREATMENT RESPONSE

Biliarypancreas MRI



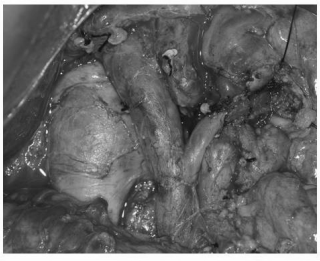
Infiltration around the CHA
→ **How can we interpret this lesion?**

Borderline resectable pancreatic cancer



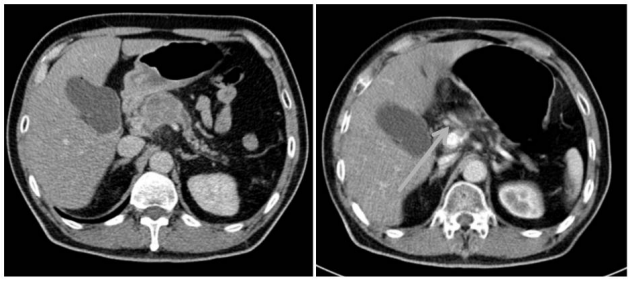
4.2cm pancreas body/head mass with main PV/SMV invasion. Perivascular soft tissue infiltration along the CHA, indeterminate.

Whipple's operation with SMV segmental resection



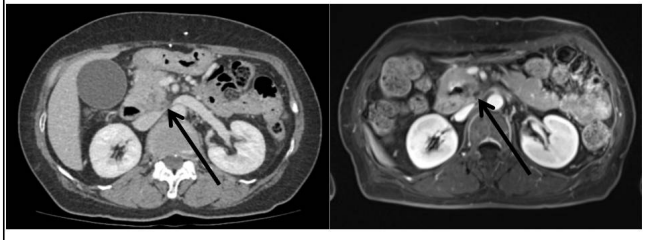
Ductal adenocarcinoma pT3N0, negative margin
→ **Postoperative 15 months, NED**

Gemcitabine CCRT, 6 cycle



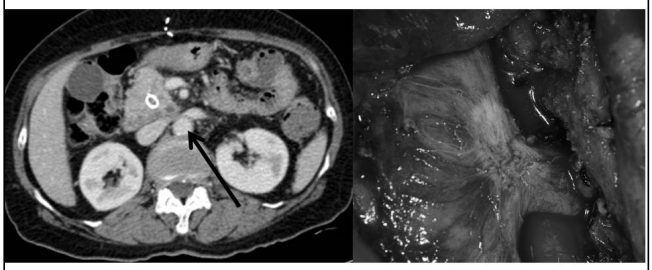
Equivocally decreased size of the pancreas cancer. No change of subtle infiltration around the CHA
→ **Which exam can be helpful?**

What about this case?



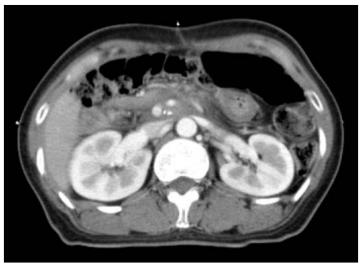
Uncinate process cancer, obliteration of the fat plane between the mass and IVC-Lt. renal vein.

Gemcitabine CCRT, 6 cycle



IVC-Lt. renal vein tumor invasion (+)

PPPD postop 4 months

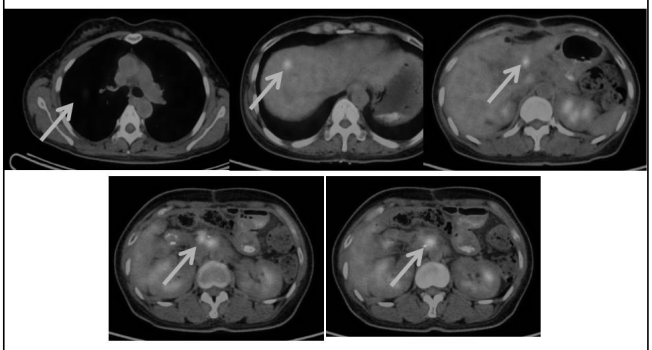


Increased soft tissue infiltration around the CHA, SMA

→ **Is further exam necessary?**

- **When should we give up operation?**
- **What can we do in cases with perivascular cuffing that does not change or increase after neoadjuvant treatment?**
- **Which exam is more reliable to interpret the treatment response after neoadjuvant treatment?**

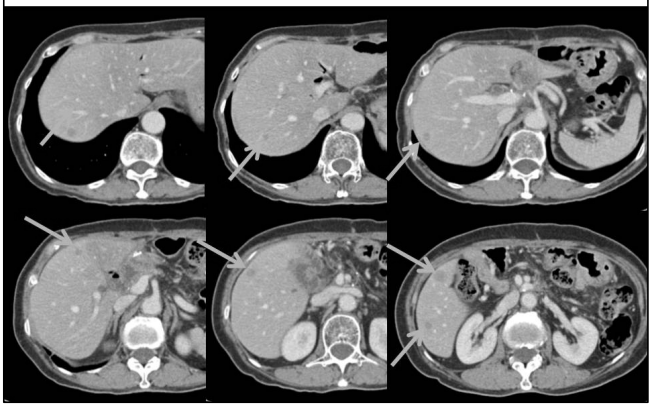
PET

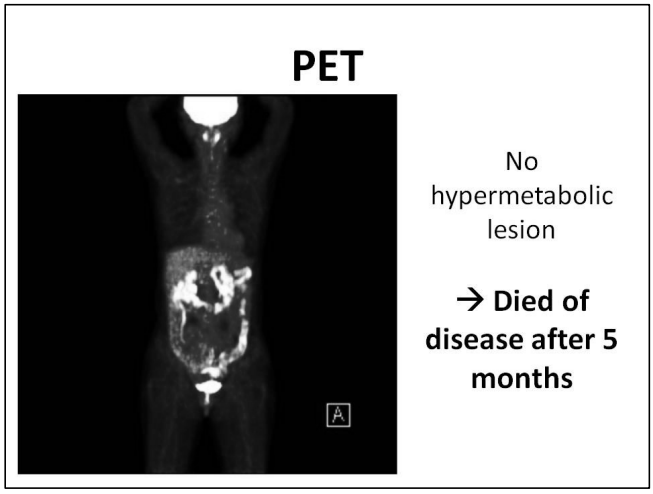


Multiple hepatic metastasis

RECURRENCE DETECTION

What about this case?





- Is routine PET necessary during follow-up after operation?
- Is PET needed in cases of suspicious disease recurrence on CT?
- When should we perform PET even there are no evidences of disease recurrence on CT?
- How much can we rely on CT or PET?

November 28(Fri), 2014,
[Grand ballroom 104, COEX]

2014년 11월 28일(금),
코엑스 그랜드볼룸 104호

Symposium 5.
Live Donor Issues (English Session)

Donor morbidity and mortality - how good are we?

Department of Surgery, Seoul National University College of Medicine, Korea
(서울대학교 의과대학 외과학교실)

Nam Joon Yi
(이남준)

Although LDLT has a low but definite donor risk, it has not been controlled under systemic review.

Most LDLT programs have institutional protocols and guidelines based on the highest ethical and medical standards to minimize live donor risk. However, the own evaluation criteria and selection protocol for living donor candidates in each LDLT center have not been evaluated well. LDLT would benefit from studies designed to validate the clinical utility and cost-effectiveness of donor evaluation protocols which may be the first step to protect the donor safety.

According to a recent worldwide survey on living donor risk by Cheah et al., 11,553 times donor hepatectomies has been performed in 71 programs of 21 countries. The average donor morbidity rate was 24%, with 5 donors (0.04%) requiring transplantation for themselves. Most events (85.8%) occurring within the first 30 postoperative days. The donor mortality rate was 0.2% (23/11,553), and all but 4 deaths were related to the donation surgery