

(15%), including pleural effusion requiring percutaneous drainage in 3, biliary fistula requiring percutaneous drainage in 4, transient hemodynamic instability in 1, and relaparotomy because of small bowel obstruction in one patient. The 1-, 3- and 5-year overall survival rate was 97, 59 and 32 per cent respectively. Median overall survival was 39.6 months. The 1-, 3- and 5-year disease-free survival rate was 45, 17 and 11 per cent respectively, with median disease-free survival of 9.4 months. The report from the other experienced HPB surgeons also showed similar results, acceptable mortality rate (0-7%) and 5-year-survival rate (32-64%). It has been reported that this procedure is feasible and useful in the view of both safety and oncological aspects.

ALPPS consists of initial open right PVL with in-situ splitting of the liver parenchyma, followed by re-exploration for right trisectionectomy. Using this procedure, the FRL volume considerably increased within short duration after surgery, and achievement ratio is higher than "conventional" TSH. The incidence of severe morbidity and mortality in patients undergoing ALPPS was reported to be considerably high (severe morbidity; 27-73%, mortality; 0-28%). In addition, long-term results have not been clarified yet so far. One study reported that 6 of 7 patients undergoing ALPPS had tumor recurrence within 13 months after surgery. To date, there has been no evidence that ALPPS will surpass "conventional" TSH in short and long-term outcome.

In this context, surgeons should be revisited before performance of ALLPS if it would be really necessary and make an effort to look for the alternative. In our opinion, a reappraisal of "conventional" TSH should be undertaken before proceeding to the next step of "development" concerning this procedure.

Liver

Special Lecture (English Session)

Current thoughts on management of pancreatic cystic neoplasm

Department of Surgery, International Patient Center, Massachusetts General Hospital, USA

Andrew L. Warshaw

Current consensus guidelines, validated by experience, indicate the advisability of resecting all main-duct IPMN because of a high prevalence of malignancy in the range of 60%. The consensus guidelines for branch-duct IPMN, which carry a risk of <20% overall, are still undergoing modification. While it is clear that symptoms and solid components are indices of likely cancer, the incidence of cancer in cystic lesions of various sizes, greater or less than 3 cm, is in dispute. The different epithelial subtypes of branch-duct IPMN have different risks of undergoing malignant change and different prognoses after resection. In addition there is heightened risk of concomitant or metachronous development of a separate and distinct pancreatic ductal adenocarcinoma (PDAC). The criteria for surgical resection or for ongoing surveillance, as well as the need for post-resection surveillance, remain uncertain but are of significant importance. The analysis of pancreatic cyst fluid for CEA, GNAS, K-Ras, and Das-1 may help determine the therapeutic decisions.