

Distal Pancreatectomy Combined with Celiac Axis Resection: An Alternative Approach for Some Advanced Distal Pancreatic Cancer

TO THE EDITORS:

We read the comments by Yang et al. with great interest. Extended radical resection for pancreatic cancer remains a controversial problem because of the complexity of the surgical procedure itself and lack of evidence of survival benefit. We applied this approach to treating the patients with pancreatic body/tail carcinoma involving celiac axis (CA) or common hepatic artery (CHA) only and expected to improve the quality of life and prolong the survival time. Sener et al. also noted that the best survival rates per stage were achieved after surgical resection.¹

As Yang et al. discussed, some of our patients in group C were actually stage IV because they did not receive any exploratory procedure. We cannot exclude this possibility. However, the question remains whether stage III patients survive significantly longer than stage IV patients, and how many patients in group C actually belonged to stage IV. Laparoscopic exploration to exclude this small subset of patients might be a reasonable option in the future management of advanced pancreatic body/tail carcinoma. They also mentioned that such locally advanced pancreatic tumors might have synchronous systemic metastases at the time of the operation. This is possible; however, it is rational to proceed with more aggressive surgical procedures as long as the patient's condition fulfills the criteria mentioned in our article, and our results did show survival benefit with the modified Appleby procedure.

In recent decades, regional pancreatectomy and en bloc vascular resection for pancreatic cancer had been gradually accepted with the improvement of surgical techniques. Although most researches were retrospective studies, it could be concluded that the survival of patients received pancreatectomy combined with vessel resection was similar to those without vascular resection.^{2,3} That is to say that

en bloc vascular resection is an alternative approach for some advanced pancreatic cancer. It not only increases the resectability but also can acquire benefit in both survival and life quality.

Pancreatic cancer involved CA/CHA had been regarded as unresectable in the past. However for pancreatic body/tail cancer, CA resection could be preceded safely provided that the collateral blood supply from SMA via the pancreaticoduodenal arcades and gastroduodenal artery (GDA) to the liver and stomach were well preserved. Otherwise, there must be salvage means for ischemia-related complications after CA resection, including preoperative coil embolization of the CHA and intraoperative reconstruction of the CHA. Of course, this procedure should be uniformly performed by experienced surgeons.

We believe that distal pancreatectomy combined with CA resection for the treatment of carcinoma of the body/tail of the pancreas could be performed by an experienced surgeon and could have benefits for some advanced pancreatic body/tail cancers. Our study is the first to compare different modalities regarding the treatment for distal pancreatic cancer; however, the real value of such treatment should be validated by other groups, ideally some large-scale prospective randomized studies.

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