



Abstract PMO-094 Figure 3 SULF2 knockdown inhibits cell growth.

Competing interests None declared.

Pancreas

PMO-095 LAPAROSCOPIC VS OPEN PANCREATICODUODENECTOMY: ONCOLOGICAL OUTCOMES USING LEEDS PATHOLOGY PROTOCOL (LEEPP)—A MATCHED-PAIR ANALYSIS

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Introduction Laparoscopic Pancreaticoduodenectomy (LPD) has recently been shown to be a technically safe procedure. Oncological safety of LPD is still a matter for debate. Currently, there is limited evidence for cancer outcomes following LPD, especially in comparison to Open Pancreaticoduodenectomy (OPD). The aim of this study is to compare the adequacy of cancer resection and outcome following LPD and OPD.

Methods Between November 2005 and April 2009, 12 LPD's (nine ampullary and three distal Common Bile Duct tumours) were carried out in a tertiary referral centre. A cohort of 12 patients who underwent OPD from November 2003 to February 2007 were matched for age, sex, site of tumour origin and tumour size. Histology was assessed using previously validated Leeds Pathology Protocol (LEEPP) (Ref). The primary aim was to evaluate margin involvement and mean number of lymph nodes excised. The secondary endpoints were complications, high-dependency unit (HDU) stay, length of hospital stay (LOS), recurrence and mortality rate. The median follow-up was 46.8 months for LPD and 56.0 months for OPD.

Results R0 resection was achieved in 9 LPD vs 8 OPD ($p=1.000$). The T staging T2, T3, T4 were 6, 4, 2 for LPD vs 6, 5, 1 for OPD respectively ($p=1.000$). The mean tumour size was 19.8 for LPD Vs 19.2 for OPD ($p=0.870$). The mean number of lymph node excised for LPD vs OPD (20.7 vs 18.5, $p=0.534$). Clavien grade I/II complications (5 vs 8), Clavien grade III/IV complications (2 vs 6) and pancreatic leak (2 vs 1) were statistically not significant (LPD vs OPD). The mean HDU stay was longer in OPD group (3.7 vs 1.4 days, $p<0.000$), but LOS was no different (14.9 vs 14.9 days, $p=1.000$). There were two recurrences each in LPD and OPD group ($p=1.000$). Overall mortality for LPD vs OPD (2 vs 6, $p=0.193$) and recurrence-related mortality (2 vs 2, $p=1.000$).

Conclusion Compared to open procedure, in patients with tumour size <2 cm, laparoscopic pancreaticoduodenectomy achieves similar rate of R0 resection, lymph node harvest and long-term recurrence. LPD patients have significantly shorter high-dependency stay and lesser post-operative complications. Though technically challenging, laparoscopic pancreaticoduodenectomy is safe and does not compromise oncological outcome for tumours <2 cm.

Competing interests None declared.

REFERENCE

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PMO-096 LAPAROSCOPIC DISTAL PANCREATECTOMY—A TERTIARY REFERRAL CENTRE EXPERIENCE

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Introduction Laparoscopic distal pancreatectomy was first reported in 1996 and is increasingly employed to remove lesions from the body and tail of the pancreas. The technique has seen a slow progress due to a relatively low volume of caseload, the lack of standardisation in the management of the pancreatic stump and concerns about the ability to achieve negative surgical margins for benign or malignant pancreatic neoplasms.

Methods Data were collected by retrospective review of case notes and histopathological results. 20 patients underwent laparoscopic distal pancreatectomy from April 2009 to January 2012.

Results 20 patients were included in the study, 0.45:1 male: female ratio (nine males, 20 females), mean age 58.55 [range 25–83]. In most cases the indication for surgery was a cystic lesion in the tail of pancreas (45%). The spleen was preserved in 15 cases (75%). None of the patients in this series required conversion from laparoscopic to open surgery or blood transfusion. Four patients (20%) were transferred to HDU postoperatively for 1–5 days and the mean hospital stay was 8.5 days [range 3–23 days]. Four patients (20%) had postoperative complications: one had partial splenic infarction which was managed conservatively, one had fluid collection that was treated by percutaneous drainage, one had a pancreatic stump leak that settled conservatively and one had abscess which required surgical intervention. The latter had laparoscopic right hemicolectomy at the same time of his pancreatic resection. There was no indication of a pancreatic fistula at follow-up. Histology confirmed one chronic abscess, one congenital cyst, five cancers, six potentially malignant lesions and seven serous microcystic cystadenomas. All tumours were completely excised with clear resection margins.

Conclusion Laparoscopic resection is feasible and achieves adequate resection margins.

Competing interests None declared.

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PMO-097 SURGERY FOR PANCREATIC CANCER WITHOUT PREOPERATIVE BILIARY DRAINAGE: FICTION IN REALITY?

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Introduction A recent article published in the New England Journal of Medicine describes decreased complication rate in patients who have not had preoperative biliary drainage of their obstructive jaundice caused by their pancreatic mass. Unfortunately our perception is such that the reality of early surgery without a bridging stent hangs in the realms of fantasy. Our aims were to