Between November 2005 and April 2009, 12 LPD methods study is to compare the adequacy of cancer resection and outcome to Open Pancreaticoduodenectomy (OPD). The aim of this evidence for cancer outcomes following LPD, especially in comparison to Open Pancreaticoduodenectomy (OPD). 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 25–85]. 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 serious microcystic cystadenomas. All tumours were completely excised with clear resection margins.

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 25–85]. 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 serious 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.

REFERENCES

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

doi:10.1136/gutjnl-2012-302514b.96

1 A Mohan,* 2 P Griffiths, 1 T Brown, 1 Al-Sairieth, 1 Pancreatic Unit, Morriston Hospital, Swansea, Swansea, UK; 2 Department of Histopathology, Morriston Hospital, Swansea, Swansea, UK

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 25–85]. 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 serious 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.

REFERENCES

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

doi:10.1136/gutjnl-2012-302514b.97

C Daker,* N van Someren, K Besherdas. Department of Gastroenterology, Chase Farm Hospital, London, UK

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

Competing interests None declared.

REFERENCES

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

doi:10.1136/gutjnl-2012-302514b.97

C Daker,* N van Someren, K Besherdas. Department of Gastroenterology, Chase Farm Hospital, London, UK

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
analyse the outcome of patients diagnosed to have pancreatic cancer in clinical practice in North London.

**Methods** In this duel centre retrospective study, a years worth of pancreatic cancer diagnoses was compiled using the North London Cancer Network Multi-disciplinary team meeting data base. The patients records were then searched gathering information on their dates of diagnosis; referral to our hepatobiliary surgeons at a local tertiary referral centre; whether they had a pre-operative stent; the date of their surgery (if they survived long enough to have it) and they’re ultimate outcome.

**Results** 68 patients within our sector received a diagnosis (histological/endoscopic/radiological) of pancreatic cancer over the course of 1 year (May 2010—May 2011). Of this cohort 20 (29.4%) were referred for surgical opinion. During the lag between diagnosis and surgical review, 9 (45%) patients received endoscopic biliary drainage and stent insertion (all were 1st pass). The total number to ultimately receive their Whipple’s was 5 (25%). In four patients in whom surgery was felt to be an option, aggressive disease and complications leading to a lengthy in patient stay at the point of diagnosis meant that the physical condition of the patient had deteriorated to the point where they were no longer fit for surgery/inoperable. Only one patient proceeded straight to operation without prior stenting. Two patients had their operations privately. Unfortunately details of any post operative complications are not available.

**Conclusion** Our experiences of pancreatic cancer is that at the point of diagnosis most cancers were inoperable 48 of 68 (70%). Within our study period only 5 of 68 (7%) patients had surgery for pancreatic cancer. The majority of patients even when initially considered for surgery (75%) do not end up having a resection. When patients are referred with symptoms of obstructive jaundice, knowing that the majority will not undergo surgery and also knowing in clinical practice that it is difficult to get surgical resection within 10 days of diagnosis, the humane thing to do instinctively is to stent and achieve biliary drainage. Achieving biliary drainage helps in improving the patients symptom profile and additionally allows chemotherapeutic options in those whose jaundice resolves.

**Competing interests** None declared.

**REFERENCES**


**PMO-099 A COMPARATIVE STUDY OF LAPAROSCOPIC VS OPEN DISTAL PANCREATECTOMY**

doi:10.1136/gutjnl-2012-302514b.99

D J Maide,* Y Khalid, J Packer, R Deshpande, D O'Reilly, D Sherlock, B J Ammon. The HPB Unit, North Manchester General Hospital, Manchester, UK

**Introduction** The laparoscopic approach to distal pancreatectomy for benign and malignant diseases appears to offer advantages and is replacing open surgery in some centres. However, well-designed studies comparing laparoscopic distal pancreatectomy (LDP) to open distal pancreatectomy (ODP) are limited. We present a single-institution study comparing the outcomes of LDF to ODP.

**Methods** The demographic details, clinical characteristics and outcomes of patients who underwent laparoscopic distal pancreatectomy were compared to those who had the surgery performed by open technique. The two approaches were compared on an intention-to-treat basis. Data shown represent medians. The two approaches were compared on an intention-to-treat basis. Data shown represent medians.

**Results** Between 2002 and 2009, 52 patients (20 female) underwent 16 LDF and 16 ODP respectively. The laparoscopic and open groups were comparable for age (57 vs 63 years, p=0.584), sex distribution and tumour size (3.9 vs 4 cm, p=0.959). Both groups had a comparable number of malignant cases (56% vs 50%, p=1.0). Although LDP took longer to complete (287.5 vs 240 min, p=0.061), it was associated with significantly lower blood loss (500 vs 500 ml, p=0.051) but comparable perioperative transfusion rate (p=0.471). The laparoscopic approach was associated with a significantly higher spleen-preservation rate (overall: 50% vs 12.5%, p=0.05; benign pathology: 85.7% vs 25%, p=1.0). LDP patients had a significantly lower HDU stay (1 vs 4.5 days, p<0.001) and a significantly lower postoperative hospital stay (6.5 vs 13.8 days, p=0.001). There was no significant difference in the postoperative morbidity and the R0 resection margin status.