EP02E-055
LAPAROSCOPIC PANCREATICO-DUODENAL RESECTIONS: EARLY EXPERIENCE FROM A TERTIARY CENTRE

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Background: Laparoscopic distal pancreatic resection has gained acceptance and being practised in major HPB units. Laparoscopic pancreatico-duodenal resections are technically demanding and benefit of this approach has been a matter of debate over the past decade. We aim to analyse our early experience in laparoscopic pancreatico -duodenal resections.
Methods: From November 2012 to August 2015, we have performed 8 pancreatico-duodenal resections. There were 2 total pancreatectomies and 6 Whipple's resections. The laparoscopic approach was using 5 ports with patient in supine position. We describe the patient characteristics, techniques and short- term outcomes.
Results: The median age was 56 years (39−75) and M:F was 2:1. The Median BMI was 21 (17.5−23.5). The major indication was ampullary carcinoma. Two of the Whipple's resections had early conversion during dissection because of adjacent visceral invasion requiring extended resections. One Whipple's resection was totally laparoscopic and rest of them required a small incision to complete the anastomosis. The mean operating time was 598 min (425−689). One patient had grade A pancreatic leak that was managed conservatively. The median length of stay was 11 days (6−22). The median tumour size was 19.3 mm (9−30).The mean lymph node yield was 20 (10−24). There was one case of R1 resection margin because of tumour within 1 mm SMV margin. There were no postoperative mortality.
Conclusion: Laparoscopic pancreaticoduodenectomy is feasible and safe in selected group of patients performed by experienced surgeons. The oncological and the short term outcomes are similar to open resections.

EP02E-056
FALSE ANEURISMS OF VISCERAL ARTERIES: RADIOLOGY METHODS IN DIAGNOSTICS AND TREATMENT

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Purpose: To define the possibilities of radiology in diagnostics and treatment tactics definition of patients with the false aneurisms (FA) of visceral arteries.
Materials and methods: 46 patients with FA passed inspection and treatment (men-54.3%, middle age − 48 ± 2.27 years) during 1995−2015. Duration of the chronic pancreatitis (CP): 6 months−15 years. Preoperative inspection: ultrasonography, MSCT, MRI/MRCP. FA arteries-sources: lienalis − 30 (65.2%); pancreaticooduodenalis − 5 (10.9%); gastroduodenalis − 6 (13.0%); left gastric − 1 (2.2%); mesenterica superior − 2 (4.3%); right hepatic artery departing from mesenterica superior − 1 (2.2%); gastroduodenalis artery and mesenterica superior vein with formation of an arteriovenous fistula through FA cavity − 1 (2.2%).
Results: FA arose because of the arrosion of vessel wall were divided into two groups: 1st (in pseudocyst cavity, possible communication with main pancreatic duct (MPD) − 33(71.7%); 2nd (in the pancreas (P) parenchyma, without communication with MPD) − 13(28.3%).

At diagnostics of FA, and treatment tactics definition it is necessary to consider the following: aneurism sizes; communication of aneurism's cavity with P duct system; existence of complications of CP current (pancreatic duct hypertension, P parenchyma calcinosis, portal hypertension).

Endovascular surgery f FA is expedient and effective, in the absence of contraindications. In the presence of indications to the surgical treatment directed on elimination of FA and other complications of CP, it is possible to carry out endovascular intervention as the Ist stage, the IInd stage − open surgery.
Conclusion: Radiology methods allows to:

1. diagnose FA and the complications accompanying it;
2. directly influence a choice of treatment tactics.

EP02E-057
A COMPARISON OF TWO PANCREATOJEJUNOSTOMY TECHNIQUES AFTER PANCREATODUODENECTOMY

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Introduction: We present our experience in the technical management of pancreaticojejunal anastomosis (PYA) after 165 duodenopancreatectomies performed by two specialized surgeons. Between 2002 and 2011, a total of 165 consecutive patients underwent elective pancreaticoduodenectomy for benign or malignant pathologies of the pancreas.
Methods: While one of the surgeons established the end-to-side PYA as standard, the other one classified his patients due to:

a) glandular consistency,
b) Wirsung's caliber,
c) possibility to mobilize the neck of the pancreas and
d) vascularization.

In those patients that fulfilled these criteria, a duct-to-mucosa PYA was performed, and an end-to side single-layer anastomosis in the rest. In this manner three groups were established:

GROUP A: elective duct-to-mucosa PYA.
GROUP B: sistematic end-to-side single-layer PYA.
GROUP C: elective end-to-side single-layer PYA.

All patients were followed until 2014, recording overall morbidity (28,5 %) overall mortality (3,84 %), days of stay (15) and survival.
Results: Group A − B −C(%):
Pancreatic fistula: 17−19−17
Biliary fistula: 9−8−7
Retardating of gastric empting: 10−13−11
Bleeding: 7−3−2

Abscess: 10−8−9
Colangitis: 2−0−0
Reoperation: 4−5−5
Morbidity: 26−29−28
Mortality: 3.1−3.8−3,9
Conclusions: There was no statistically significant difference between the two techniques, of fistula, morbidity, mortality.

EP02E-058
A NOVEL TECHNIQUE FOR LAPAROSCOPIC DISTAL PANCREATECTOMY WITH SPLENECTOMY

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In laparoscopic distal pancreatectomy with splenectomy, we describe a new technique for safe extraction of the distal pancreas along with the spleen.

This technique was employed in three cases. We placed a camera port in the umbilical region and 4 trocars in the upper abdominal region. The pancreas body was divided along with the splenic vein and splenic artery. Then the splenic artery was cut. The pancreas body was divided using a linear tri-stapler and reinforcement material. Thereafter, an extraction bag was inserted through the umbilical wound into the abdominal cavity for storage of the pancreas body and spleen. The umbilical wound was extended by 2.0 cm, and a SILS port™ was placed at the end of the bag. A pneumoperitoneum was established in the bag to obtain sufficient working space and to facilitate the division of the pancreas body and spleen within the bag. If the spleen was too large, it was divided into several portions to enable easy extraction from the abdominal cavity without the need for extending the wound.

The average total duration of the operation was 398 (317−412) minutes and the average duration of extraction was 64 (31−92) minutes. The extracted specimens could be used for pathological staging. No operation-related complications were noted. The patients were discharged from the hospital on an average of 9 (7−27) days after the operation.

Through this novel method, we could perform laparoscopic distal pancreatectomy with splenectomy in a safe manner, without extending the wound size to more than 2 cm.

EP02E-059
PANCREATICOJEJUNOSTOMY: DESCRIBING A MANEUVER THAT COULD POSSIBLY BYPASS ITS HANDICAPS

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Introduction: One of the main advantages of pancreaticogastrostomy over pancreaticojejunostomy in Whipple's procedure is that the former technique offers the option of controlling and treating possible anastomosis related complications such as bleeding through endoscopy. In the present study, we present a surgical alternative in regards to the configuration of the small bowel loop used for the pancreaticojejunostomy which could overcome access difficulties.
Methods: A 75-years old female patient underwent a classic Whipple's with a pancreaticojejunal anastomosis of the pancreatic remnant for pancreatic cancer. However, as the pancreatic remnant appeared soft in texture during the procedure rendering the anastomosis high risk of leakage we chose to "protect" the end to side pancreaticojejunostomy by bringing the free end of the small bowel loop used for the anastomosis out as a stoma (jejunostomy). The rationale behind this decision was that apart from the advantage of the optimal endoscopic assess for controlling the anastomosis was the fact that such maneuver could lower the intraluminal pressure within the small bowel loop minimizing the risk of leakage.
Results: Indeed, the patient had an uneventful postoperative period and she was discharged on the 8th postoperative day.
Conclusion: The previously described technique although not adequately tested within a properly designed study could theoretically bypass some of the handicaps of pancreaticojejunostomy over pancreaticogastrostomy. The logical assumption of minimizing anastomotic leakage by reducing the peri-anastomotic pressure needs to be tested as well.

EP02E-060
FRANTZ TUMOR, PANCREATICODUODENECTOMY ASSOCIATED WITH RESECTION OF THE MESENTERIC-PORTAL AXIS: A CASE REPORT

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Introduction: Frantz pseudopapillary solid tumor or pancreatic neoplasia is a rare disease of unknown etiology. It occurs mainly in young women, with low malignant potential and favorable prognosis.
Methods: We report the case of a 18-year-old patient complaining of pain and palpable abdominal mass. Computed tomography showed a large expansive formation of pancreatic head cystic-solid ride and intimate relationship with the superior mesenteric vein.
Results: The patient underwent a pancreaticoduodenectomy which was ratified a large mass pancreaática in its proximal third involving the mesenteric-portal axis, especially the superior mesenteric vein. We performed a resection of tumor block and mesenteric vein segment with higher performing reconstruction and primary anastomosis of vascular stumps. The histopathological and immunohistochemical examination showed a solid pseudopapillary tumor and lymph nodes without neoplastic changes. Was discharged in the eighteenth postoperative day and in the first six months of follow-up shows no clinical relapse of the disease and radiology.
Conclusion: Frantz tumor should always be considered in the differential diagnosis of pancreatic lesions in young patients, having this as a primary treatment to surgical resection. The intimate involvement with vessels of the mesenteric-portal axis does not exclude therapy should be chosen primarily by primary vascular reconstructions and complete removal of the tumor lesion.