ISW26-211-01 (0200)

EMBOLIZATION AND ADMINISTRATION OF COAGULATION FACTORS IN COMPLEX TREATMENT OF RECURRENT EROSIVE BLEEDING IN PANCREATIC NECROSIS

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Introduction:
The course of severe acute pancreatitis complicated by hemorrhage is associated with the final unfavorable outcome of treatment of this group of patients. The overall incidence of all gastrointestinal bleeding in acute pancreatitis reaches 23%. The greatest difficulty in diagnostics and treatment are arrosive parapancreatic intra-abdominal bleedings without clear arteriographic localization at the stage of development of purulent-septic complications of pancreonecrosis (fatality up to 100%). The aim of the study was to evaluate the efficacy and safety of the technique of endovascular embolization and introduction of coagulation factors in the treatment of arrosive bleedings in acute pancreatitis.

Material and Method:
The treatment of patients with pancreonecrosis in intensive care with developed arterial hemorrhage for the period of 2023-2025 was evaluated. In treatment of these patients (after ineffectiveness of standard methods of stitching and tamponade of bleeding areas) we used endovascular total embolization of splenic artery with creation of the “steal- syndrome” of blood circulation in the pancreas, and further systemic administration of coagulation factors, which in conditions of slow blood flow allows to form a stable hemostasis.

Results:
The technique was patented (Russia). In total 6 patients were treated. M:W- 5:1. The average age was 46 years (39-62). Apart from arrosive bleeding all patients had characteristic complications connected with severe course of pancreonecrosis. The lethality due to bleeding constituted 0%.

Conclusion:
Embolization of the arterial vessel supplying the pancreas in combination with systemic use of coagulation factors could to stop almost fatal parapancreatic intra-abdominal bleeding at the stage of purulent-septic complications of pancreonecrosis.

ISW26-211-03 (0746)

EXTENDED PANCREATICODUODENECTOMY FOLLOWED BY VASCULAR RECONSTRUCTION IN INCIDENTALLY DIAGNOSED BORDERLINE RESECTABLE SPINDLE CELL NEOPLASM OF PANCREAS

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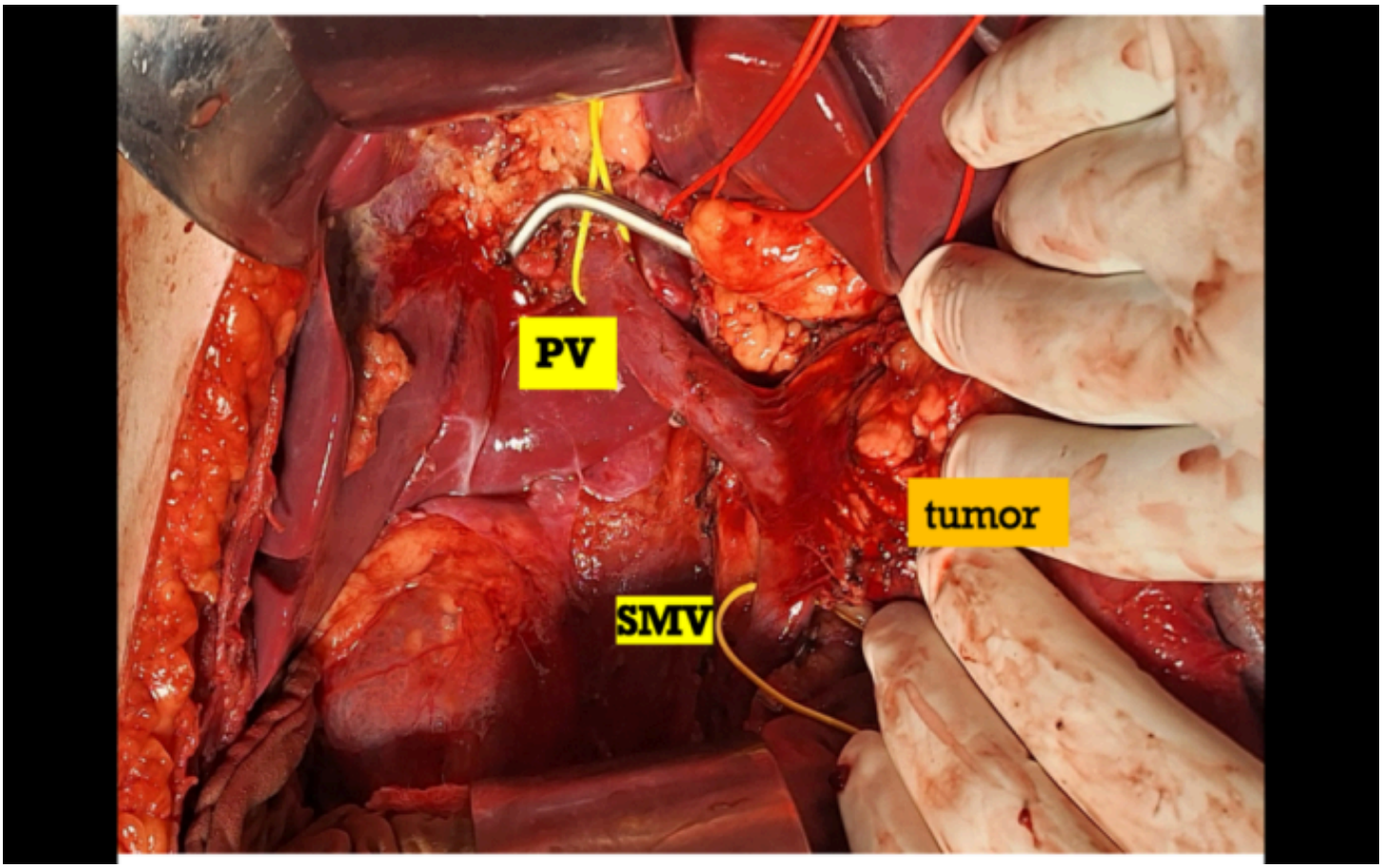
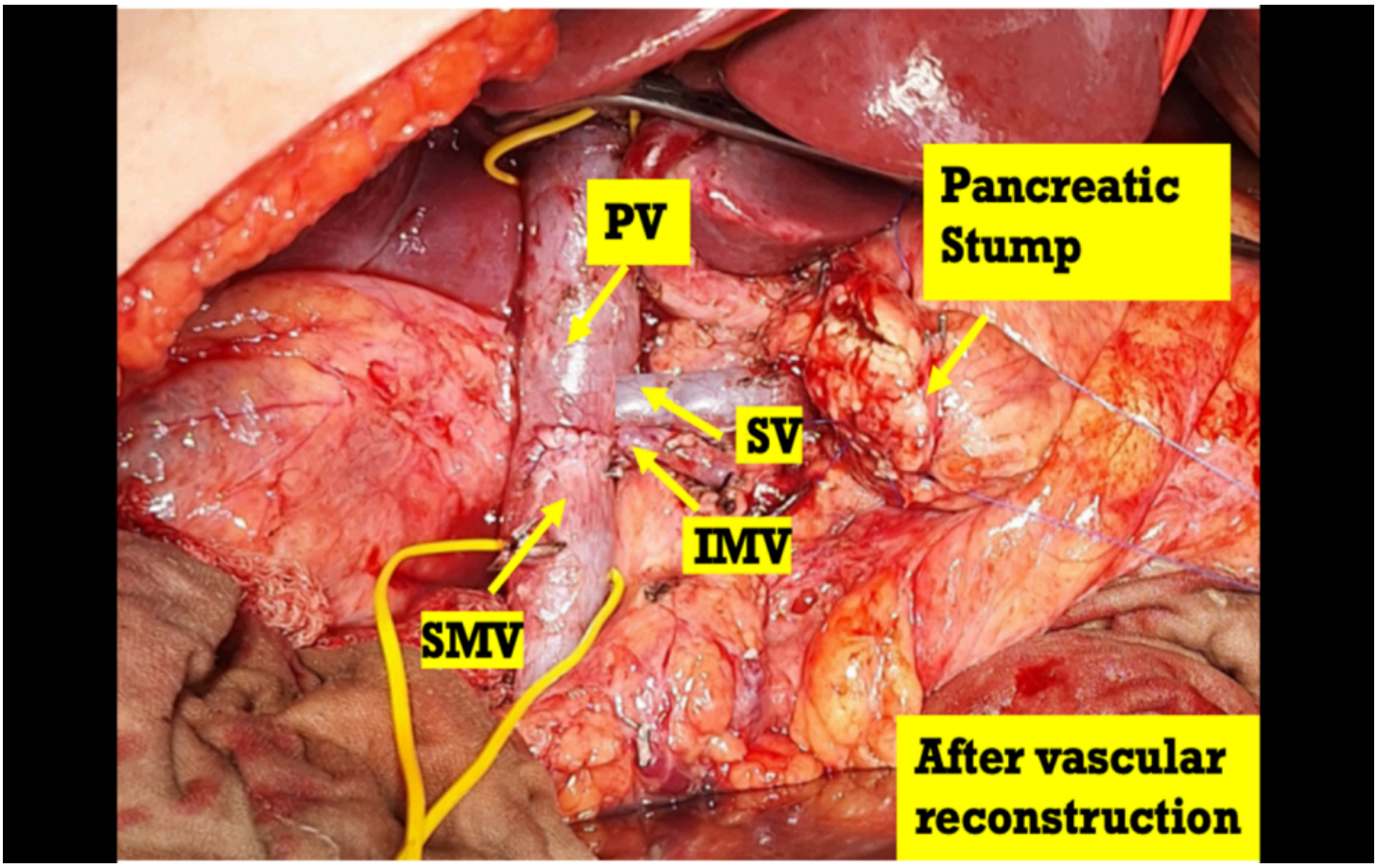
Introduction:
Pancreatic tumors involving major vascular structures have traditionally been considered inoperable due to high perioperative risk and uncertain oncological benefit. However, with advances in surgical techniques and multi-disciplinary perioperative care, this dogma is challenged as vascular resection and reconstruction can be safely performed in selected patients, potentially improving overall survival.

Material and Method:
We present a case of a 34-year-old female, incidentally diagnosed with a pancreatic mass involving the head and body during a routine health check. Triphasic CT revealed tumor compression of the portosplenic confluence. Following multidisciplinary review, an extended pancreaticoduodenectomy was planned with possible vascular resection.

Results:
Intra-operatively, the tumor in the pancreatic neck was found to invade the confluence of the portal vein, superior mesenteric vein, and splenic vein. Intraoperative ultrasound-guided pancreatic transection was performed, followed by en bloc resection and spleno-portal reconstruction using a tension-free vascular anastomosis. Postoperative Doppler ultrasound on days 1, 3, and 5 confirmed good vascular patency and flow. Histopathology revealed spindle cell neoplasm of the pancreas with all surgical margins free of tumor. The patient underwent four cycles of adjuvant doxorubicin and ifosfamide chemotherapy and remains under surveillance without recurrence to date.

Conclusion:
This case underscores that vascular involvement in pancreatic tumors should not preclude curative intent surgery. In experienced hands, combined pancreatico-vascular resection and reconstruction can yield oncologically complete resection with durable vascular patency. The potential thrombotic risk is outweighed by the survival advantage conferred by margin-negative surgery, shifting the paradigm in the surgical management of borderline resectable pancreatic tumors.


PV
tumor
SMV


PV
Pancreatic Stump
SV
IMV
SMV
After vascular reconstruction

ISW26-211-04 (1015)

INTRADUCTAL PAPILLARY NEOPLASM OF THE BILE DUCT (IPNB): A RARE CASE FROM A WESTERN COUNTRY

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Introduction:
Intraductal Papillary Neoplasm of the Bile Duct (IPNB) is a rare bile duct neoplasm, more commonly observed in Far Eastern countries, where it is associated with hepatolithiasis and clonorchiasis infections. In contrast, it is very rare in Western countries. The most common clinical manifestations include intermittent abdominal pain, acute cholangitis, and jaundice.

Material and Method:
This report describes a rare case of IPNB in a Western country. A 75-year-old woman presented with abdominal pain, cholestatic jaundice, anorexia, and weight loss of approximately one month's duration. She denied any other symptoms. Clinical examination on admission revealed jaundice and abdominal pain in the right upper quadrant without tenderness. Computed tomography (CT) and magnetic resonance cholangiopancreatography (MRCP) demonstrated findings consistent with a type IIIA Klatskin tumor. The case was discussed at a multidisciplinary team meeting (MDTM), and the patient underwent resection of the main bile duct, right hepatectomy with cholecystectomy, lymphadenectomy of the hepatic pedicle and common hepatic artery, followed by Roux-en-Y hepaticojejunostomy to the left hepatic duct.

Results:
The postoperative course was uneventful and the patient was discharged on the 9th postoperative day. The postoperative histologic exam revealed an IPNB with high-grade dysplasia.

Conclusion:
IPNB is a rare disease that can involve both the intrahepatic and extrahepatic biliary tract. It occurs most commonly in men, usually during the 6th and 7th decades of life. Because of the high risk of malignant transformation, surgical resection is the recommended treatment, with options including pancreaticoduodenectomy, hemihepatectomy and bile duct resection. However, the pathogenesis, clinical features, and outcomes remain poorly documented.

ISW26-211-05 (0669)

THELDENIYA US GUIDED MINI INCISION CHOLECYSTECTOMY; A NEW TECHNIQUE OF CHOLECYSTECTOMY THROUGH A 5CM INCISION; WITH THE USE OF A WOUND RETRACTOR DEVICE AND ULTRASONIC GUIDANCE

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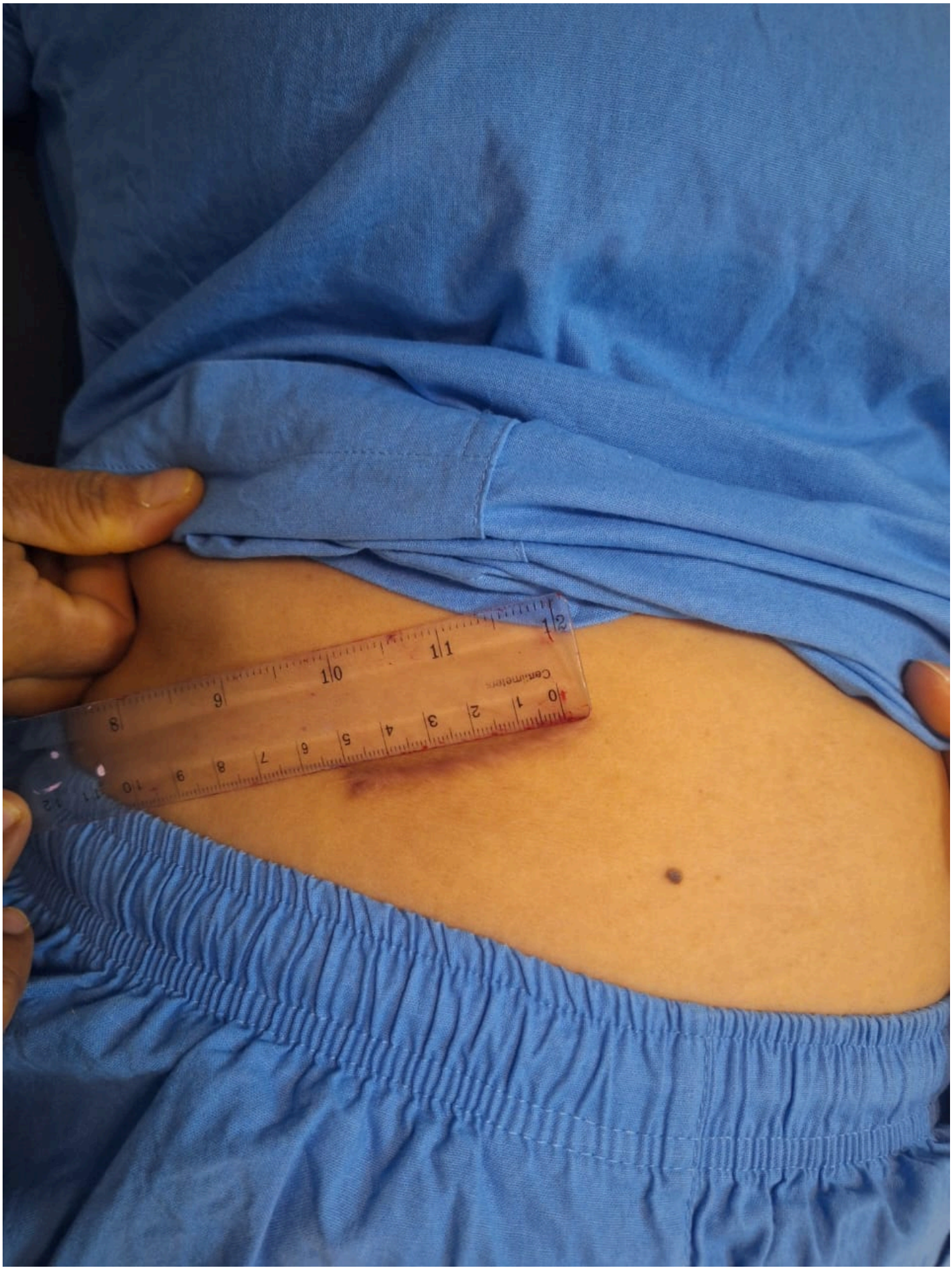
Introduction:
Current standards of care for cholecystectomy is with the use of laparoscope. Yet when that facility is not available or when that fails, standard open cholecystectomy is performed with a sub-costal incision which is generally 10cm - 15cm in length (Kocher's incision), it usually cuts through neuro-vascular bundles. As opposed to that, combined incision length of laparoscopic cholecystectomy is 5-6cm and does not entail any neuro-vascular bundle injury. Here we describe a new technique of cholecystectomy with a 5cm subcostal incision which entails no damage to neurovascular bundles.

Material and Method:
Exact position of the gall bladder fundus was marked ultrasonically. Patient under general anesthesia and supine position, a 5cm incision placed along the Langers' lines centering the fundus. Alexis medium sized wound retractor device placed which provides circumferential retraction. Gall bladder dissected with fundus first approach. From January 2022 to November 2023, fifteen (15) cases were performed. One case was converted to standard Kocher's incision due to difficult access to triangle of Calot's.

Results:
All 14 patients made an uneventful recovery. Patients reported a post op pain score of 1, in a scale of 0-4. Had no patches of anesthesia related to the incision. The patient who had standard Kocher's incision reported a pain score of 2 and had a patch of anesthesia related to the incision.

Conclusion:
Theldeniya US guided mini-incision Cholecystectomy could be a good trade-off between laparoscopic Cholecystectomy and open standard cholecystectomy. It offers minimal pain, minimal neuro-vascular bundle damage and minimal scarring.


Centimeters
0 1 2 3 4 5 6 7 8 9 10 11 12

ISW26-211-06 (0839)

RACIAL/ETHNIC DISPARITIES AND OUTCOMES OF PATIENTS WITH PANCREATIC CANCER- DATA FROM A SAFETY-NET HOSPITAL

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Introduction:
Our study aimed to describe the racial/ethnic disparities in the presentation and prognosis of pancreatic cancer, in addition to assessing factors associated with survival.

Material and Method:
We conducted a retrospective analysis of pancreatic cancer patients that presented to BUHMC from 2013 to 2022. Data was identified from the tumor registry of the hospital and the Electronic Medical Record. For our statistical analysis, African Americans were compared with other racial groups. Cox proportional hazards models were used to assess factors associated with increased mortality risk following diagnosis. A $p < 0.05$ was considered significant.

Results:
We identified 122 patients during the defined period. The median age was 68 years (IQR 59-77) and 51.6% of patients were male. Of the examined population, 93 (76.2%) were African American, 18 (14.8%) Hispanic/Latino, 7 (5.7%) non-Hispanic White and 4 (3.3%) other/mixed ethnicity. The median follow-up was 4.95 months (IQR 1.84-14.89). When comparing African Americans with other racial groups, no significant difference was found in the stage, location, or treatment of pancreatic cancer. African Americans had higher 3-year mortality rate compared to other ethnic groups ($p<0.01$). Germline genetic testing was performed only in 8 (6.6%) of the patients, one of which was positive for BRCA1 mutation.

Conclusion:
No statistically significant difference was noted in stage, location and treatment modalities between races in our cohort. African Americans had worse survival compared to other ethnic groups. Germline genetic testing was largely underutilized in our population.