Surgery for BD and LAPC after neoadjuvant treatment

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Lecture : Patients with BD and LA pancreatic cancer are better served receiving neoadjuvant therapy prior to attempted resection, particularly in the era of modern chemotherapy with FOLFIRINOX or Gem/Abraxene. In many centers, this neoadjuvant treatment (NAT)also includes chemoradiation. Although some patients will progress during chemotherapy or radiation, and others may suffer complications from the treatment , in our experience and that of others about 2/3 of patients will have resection. Many studies have now shown these resected patients have more favorable pathologic characteristics, including decrease in tumor size, lesser frequencies of nodal and perineural involvement, and a higher likelihood of an R0 resection (with some series showing > 90%). In addition, between 6 and 13% have a complete pathological response. At MGH, we recently compared the outcomes of 346 patients with pancreatic cancer who underwent resection after neoadjuvant treatment with 407 contemporary patients who underwent upfront resection. Surgery after NAT is associated with longer operative times, more blood loss, and higher need for vascular resection (all of which is expected given that tumors are BD or LA). There was no difference in operative mortality or in the rate of major complications. Notably, the rate of clinically relevant pancreatic fistula was > 3.5 times lower in the NAT group (3.8% vs 13.8%). Median survival for patients who had resection after NAT was 34 months, and was significantly better than that of the patients who underwent upfront resection (25 months). These results are so favorable that NAT is now being considered for all patients with pancreatic cancer, and not only for those with BD or LA tumors.