

Hepatobiliary and Pancreatic Oncology

Introduction

In hepatobiliary and pancreatic surgery division, we manage quite a few diseases, because the recent development of various diagnostic techniques has increased the number of borderline malignancies and benign tumors in these days. Limited resection which preserve organ function, is indicated for patients with benign or borderline malignancies. However, some diseases such as invasive pancreatic cancer, gallbladder cancer, hilar and intrahepatic cholangiocarcinoma are still associated with dismal long-term prognosis. Therefore, both medical and surgical oncology groups as an integrated clinical activity jointly treat the hepatobiliary and pancreatic tumors. As a result, our treatment regimens have developed in close co-operation with medical oncologists and radiologists.

Routine Activities

This division includes five attending surgeons, one chief resident, and four to five residents. The out patients clinic is open 5 days a week. We have staff meetings 3 times a week, and discuss the treatment strategies from medical and surgical points of view. We have a case conference of imaging diagnosis on every Tuesday in co-operation with radiologists and medical oncologists, and a monthly pathologic conference with pathologists.

Treatment strategy for HCC is based on number of lesions, tumor size and liver function. Surgical treatment is feasible in patients with relatively good liver function (Child-Pugh: A or B). When the number of tumors is 3 or less and each tumor is smaller than 30 mm in size, the efficacy of surgical treatment is similar to that of percutaneous ablation therapy. In such tumor condition, we decide the optimal treatment procedure by discussion with medical oncologist. Nevertheless, in those having tumor over

31 mm, we believe that hepatectomy is the most effective for achieving local control, if the liver function tolerates the hepatic resection.

The prognosis for patients with pancreatic cancer is dismal, and standard therapeutic strategy is not yet established. Although only surgical resection offers the hope of long-term survival, it is clear that additional therapy is needed. In order to improve the treatment results, the trial of IORT had been indicated to the patients in addition to the surgical resection, although efficacy of IORT is still controversial. Therefore, we conducted a multi-institutional prospective randomized trial, comparing therapeutic efficacy between surgery alone and that with IORT. The patients with resectable pancreatic cancer are preoperatively randomized into the IORT group or surgery alone group. The former group received IORT (25Gy) to the tumor bed after curative resection. On the other hand, we have been trying to progress limited surgery, such as duodenum-preserving pancreas head resection, local resection of inferior head of the pancreas and partial pancreatic resection, for the patients with borderline malignancies and benign tumors (intraductal papillary-mucinous neoplasm, solid-pseudopapillary tumor and endocrine tumor).

In biliary tract cancer, we perform surgical therapy for the patients without distant metastases. We think that extended hepatic resection is necessary for the patients with gallbladder cancer and hilar cholangiocarcinoma. In the patients with advanced gallbladder cancer, we perform systematic S4a+5 hepatectomy or extended right hepatectomy. In those with hilar cholangiocarcinoma, we perform right or left hepatectomy with resection of the caudate lobe. In those with disease requiring more than a right hepatectomy, transileocecal portal embolization is performed before the surgery.

Since the opening of NCCHE, we have

aggressively performed hepatic resection for liver metastasis from colorectal cancer. Extended lobectomy plus partial resection is considered as the upper limit of hepatectomy. Recently, systemic chemotherapy for colorectal cancer has been improved. Therefore, we start adjuvant chemotherapy using 5-FU, folic acid and irinotecan after hepatectomy for liver metastasis on pilot study.

the management of patients. From January, 2003, a CP was introduced in the management of hepatectomy without reconstruction of bile duct at our division. From January to December, 2004, a CP was implemented for 115 patients underwent hepatectomy without reconstruction of bile duct. The percentage of patients completing the CP was 80%. The mean postoperative length of stay was 9.0 days.

New Development in 2004

A clinical pathway (CP) was designed to assist in

● J. Furuse ●

Number of operation cases

	2002	2003	2004
HCC	56	67	69
CCC	4	3	5
Liver metastasis	64	54	61
Biliary tract	23	29	28
Pancreas	30	35	41
Others	33	26	18
Total	210	214	222