Laparoscopic liver resections: A single centre experience

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From January 2013 to December 2015, basing on multidisciplinary evaluation, consecutive fit patients (ECOG-PS) with resectable, locally advanced (T3-4,N0,M0 and AnyT,N+,M0) OJC were enrolled to receive neoadjuvant concurrent chemo-radiotherapy (5 courses of carbo-taxol regimen – radio 41,4 Gy in 23 fractions). Patients showing no progression during treatment were evaluated for oesophagectomy. Data concerning patients' characteristics, toxicity and response to therapy, postoperative and oncological outcomes were recorded. Statistical analysis was performed using SPSS Statistics (v20).
Forty-seven patients were included within study period. Most patients were male (83 Vs 17%), median age was 65 years (range 40–81) and ECOG-PS was generally low (0–1). Adenocarcinoma was the most common subtype (63,8%); tumors were frequently located within lower and junctional oesophagus (66%). Toxicity was largely mild (74,5%); 11 pts (23.4%) experienced severe haematological or gastrointestinal toxicity and 8 of them (17%) did not receive a complete CROSS regimen.
Ten patients did not undergo surgery due to progression diseases (5 pts), unfitness (2) and death after treatment (2 myocardial infarction and 1 aortic dissection). Thirty-seven patients (78,7%) underwent resection through thoraco-abdominal (4 pts), Ivor Lewis (25) and Mc Keown (8) oesophagectomy. Postoperative morbidity (CD > 3) and mortality rates (in-hospital mortality) were respectively 29.7% (11 pts) and 8,1% (3 pts). Complete pathological responses were 7 (18,9%). After a median follow-up of 11.5 months, actuarial overall and disease-free survival at 30 mos were 73.3 and 73.5% respectively. The recurrence rate was nearly 25% (9 pts). Survival and recurrence rate were not strongly associated to downstaging ($p = 0,611$ and $p = 0,68$ respectively). Most recurrences occurred outside the treatment field (radiotherapy and surgery). CROSS regimen is considered safe and effective; our limited experience suggests the need of careful patient selection to improve the results of tri-modality treatment.

MINIMALLY INVASIVE SURGICAL APPROACH FOR RADICALIZATION OF INCIDENTAL GALLBLADDER NEOPLASM: SAFETY, FEASIBILITY AND SHORT TERM OUTCOMES

S. Garritano[1,*], M.G. Spampinato[2]. [1]*Policlinico Umberto I, Roma, Italy;* [2]*Policlinico Abano Terme, Abano Terme, Italy*

* Corresponding author.

Gallbladder carcinoma is a rare but aggressive malignant neoplasm. The incidence of intra or post-operative incidental gallbladder carcinoma diagnosis following laparoscopic cholecystectomy is estimated to be 0,2-2,8%. Aggressive re-resection is warranted as the majority of patients have residual disease either in the liver or the lymph nodes. However the use of a minimally invasive surgical approach (MIS) to perform a radicalization in these patients has not been investigated yet. We retrospectively analyzed surgical and oncologic outcome of a small selected cohort of patients with incidental gallbladder carcinoma whom underwent redo radicalization surgery by MIS.
From April 2012 to June 2014 at our department 6 patients (3 females and 3 males) with incidental findings of gallbladder carcinoma pT1b (stage I) following laparoscopic cholecystectomy underwent a redo surgery for radicalization by means of laparoscopic (n. 3) or robotic approach (n. 3). A retrospective analysis of prospective collected data was performed.
The redo procedure consisted of a liver resection (segments IVb + V) and lymph nodes clearance of hepatoduodenal hilum and common hepatic artery. Conversion rate was zero. Median operative time was 290 (250–310) min. Estimated blood loss was 175 (100–350) ml. Total hospital stay was 6 (5–10) days. All liver resections were performed without inflow vascular clamping. One patient was re-operated for hemoperitoneum while peri-operative mortality was zero. Oncologically, an R0 resection was always achieved with a number of lymph nodes retrieved of 17,5 (14–22). The stage of the neoplasm was confirmed in all cases but one who was found to have a pN1 status (stage IIIb). At 21 (6–32) months follow up all patients are alive and no recurrences have been observed. Our data suggest that radicalization of patients with stage I incidental postoperative gallbladder carcinoma can be done by a MIS without compromising the oncologic outcome. Larger studies are needed to validate these results.

LAPAROSCOPIC LIVER RESECTIONS: A SINGLE CENTRE EXPERIENCE

C. Bizzoca[*], E. Maselli, L. Vincenti. *Polyclinic Hospital, Bari, Italy*

* Corresponding author.

Laparoscopic liver resections (LLR) represent the new frontier of liver surgery. During the last decade indications for the laparoscopic approach to the liver have been widely extended, from peripheral benign lesions to malignant neoplasms, “difficult” localizations and major resections.
The aim of this retrospective study is to analyzse the short- and medium-term outcome of LLR in a series of 54 patients of a single-surgeon experience.
During the period between December 2004 and June 2015, at the Department of General Surgery “Balestrazzi” of the Polyclinic Hospital in Bari, a single surgeon performed 228 hepatic resections, 54 in laparoscopy. The indication was usually a single lesion, except in two cases; the diagnosis was a malignant neoplasm for 39 patients (21%), a benign lesion in 10 cases (5,4%), uncertain in 5 patients (2,7%, intraoperatory diagnosis). 27 patients were male and 27 were female (M/F 1), with a mean age of 60 years (range 23–88). The majority of patients (46) had a good preoperatory hepatic function, assessed with the Child-Pugh score (class A). The extension of the hepatic resection varied from “wedge” resections (69%) to more challenging operations, such as settoriectomies (16%) or left hepatectomy (2%). The postoperatory morbidity and mortality rates and the time of discharge have been analyzed. A negative histological margin has been considered as indicator of a radical operation.
Nor mortality nor major complications (grade III-IV according to the Clavien-Dindo classification) have been observed. 3 patients needed blood transfusion and only two surgery-related complications occurred (3,7%), none of them requiring reintervention. The median time of discharge was 5 days (range 2–11). A negative histological margin (R0) was obtained in 89% of cases.
Laparoscopic liver surgery is a safe option for patients who need hepatic resection for benign or malignant lesions. To reach the best outcome it is of paramount importance ato have a good selection of patients, according to the experience of the surgeon in laparoscopic as well as hepatobiliary surgery.

RECENT ADVANCES IN NEOADJUVANT THERAPY FOR RECTAL CANCER

L. Panier Suffat[*], C. Piva, P. Sciacero, S. Bombaci, B. Scapino, L. Bertotti, E. Barengo, L. Rosato. *ASL TO 4, Ivrea, Italy*

* Corresponding author.

Introduction: surgical resection combined with pre operative chemio-radio therapy (CRT) is the gold standard in the treatment of T3-T4 and/or node positive cancer of the mild and low rectum. The interval between CRT and surgery is established in 6–8 weeks, balancing the oncological results with the surgical complexity. Recent Literature studies underline that prolonging the interval over 10–12 weeks may lead to significantly higher rates of tumor down staging and complete pathological response.
Patients and methods: within a cohort of 70 patients treated with pre-operative CRT and surgery for locally advanced rectal cancer between 2006 and 2015, we retrospectively evaluated a subgroup of 47 patients who underwent surgery after a prolonged interval of 10 weeks or more. Radiotherapy consisted in a total dose of 50–50.4 Gy at 1.8–2 Gy/die, 5 days/week associated with concomitant capecitabine or 5-fluorouracil. All patients were restaged before surgery. The primary endpoint was pathological complete response (pCR) after CRT.
Results: in our cohort, a pCR (pT0N0) was achieved in 7 patients (14.9%), while a pT1N0 and pT2N0 stage were shown in 4 (8.5%) and 12 patients (25.5%), respectively. Overall, a down staging with a pathological TNM lower than the clinical TNM was obtained in 37 patients (78.7%). From the surgical point of view, there were no short-term morbidity, no more technical complexity or perineal and anastomotic complications.
Discussion: the interval between CRT and surgery remain controversial. In fact it has the role to optimize the results of neo adjuvant therapy on local tumor regression avoiding the risk of neoplastic progression during the wait for surgery. Rectal cancer is responsive to CRT and this answer is time