

Staging Laparoscopy for Pancreatic Cancer Should Be Used to Select the Best Means of Palliation and Not Only to Maximize the Resectability Rate

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Staging laparoscopy, based on the assumption that endobiliary stenting is the best palliation, allegedly saves an "unnecessary" laparotomy for incurable pancreatic cancer. Our aim was to determine survival of patients with *clinically resectable* pancreatic cancer that is found to be unresectable intraoperatively and thereby infer appropriate utilization of staging laparoscopy. A retrospective analysis was undertaken of 148 patients with ductal adenocarcinoma (1985 to 1992) with a clinically resectable lesion based on current imaging techniques. All were considered candidates for resection but were deemed unresectable at operation because of metastases to the liver (group I; 29 patients), the peritoneum (group II; 22 patients), or distant lymph nodes (group III; 44 patients) or because of vascular invasion (group IV; 53 patients). Overall median survival was 9 months (range 1 to 53 months), but by group was as follows: group I, 6 months; group II, 7 months; group III, 11 months; and group IV, 11 months. Individual comparisons showed shorter survival for patients with distant nodal, liver, or peritoneal metastases than with nodal or vascular involvement ($P < 0.03$). Staging laparoscopy should be performed to identify patients with liver or peritoneal metastases who have an expected survival of approximately 6 months, in whom short-term endoscopic palliation is satisfactory. Extended laparoscopy to identify lymph node or vascular involvement is contingent upon which palliation (operative vs. endoscopic) is considered most appropriate. Because we believe operative bypass provides better, more durable palliation in this latter group, we have not adopted extended laparoscopy. (J GASTROINTEST SURG 1999;3:111-118.)

KEY WORDS: Pancreatic cancer, staging laparoscopy, palliation, survival

Laparoscopic staging of patients with periampullary malignancies has been suggested as a minimal access technique to increase the rate of curative resection,¹⁻³ and thereby decrease the number of "unnecessary" noncurative, nonresective operations. By recognizing the presence of peritoneal and/or liver metastases,^{2,4} or with more advanced laparoscopic techniques also determining distant nodal or vascular involvement,³ the rate of resectability has been increased to 75% to 90%,²⁻⁴ thereby *allegedly* saving many patients a nonresectional and thus unnecessary celiotomy.

Despite its ability to recognize disease that is unresectable for cure, we believe that staging laparoscopy should be considered not primarily to increase resectability rates but rather to select the best means for

palliation of unresectable disease. Our hypothesis in this study is that patients with pancreatic cancer deemed "resectable" by currently accepted imaging techniques, but proven to be unresectable for cure only at the time of exploration for potential resection, have survival times that vary according to the reason for unresectability (i.e., liver vs. peritoneal vs. nodal metastases vs. vascular involvement), and thus the best means of palliation for these patients (endobiliary stent vs. operative bypass) may vary accordingly. Our aim in this group of selected, good-risk patients was to determine survival separately for those with either liver, peritoneal, or distant nodal disease and those with locally advanced vascular involvement, and thereby to infer the optimal means of palliation based on expected survival. Our bias is that for pa-

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