Tumor progression following portal vein embolization for colorectal liver metastasis: impact on long-term outcomes
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INTRODUCTION: Portal vein embolization (PVE) occasionally is required prior to surgical resection for colorectal liver metastasis (CRCLM) to achieve respectability, but it may cause tumor progression. We aimed to evaluate the long-term outcomes of patients with disease progression after PVE.

METHODS: Between 2003-2013, CRCLM patients requiring PVE prior to hepatectomy were included. Clinical variables collected from our CRCLM database and 3 dimensional CT volumetric analysis for tumor volumes were assessed pre and post PVE. Survival was evaluated and follow-up confirmed with our national population registry.

RESULTS: 136 patients were included. Ninety-four (69.1%) patients had tumor progression with 10.3% developing new contralateral lesions; 42(30.9%) had stable disease post PVE. Less patients had tumor progression with 10.3% developing new contra-

CONCLUSIONS: Resectability is a more important determinant of long-term outcome than tumor progression post-PVE. The benefit of surgery is clear in terms of overall survival regardless of tumor growth. However, short- and long-term outcomes of this procedure are conflicting. We conduct this study to clarify whether MSP is safe and effective for lesions located in mid-portion of pancreas.

METHODS: Perioperative and follow-up outcomes of patients who underwent MSP between 2004 and 2013 at a high-volume center in China were compared to those of patients who underwent distal pancreatectomy (DP).

RESULTS: A total of 76 patients underwent MSP (female, 48; male, 28, median age=52). Most common indications included serous cystadenoma (n=23), mucinous cystadenoma (n=8), pancreatic neuroendocrine tumors (n=18), solid–cystic papillary tumor (n=12), and intraductal papillary mucinous neoplasm (n=7). Three cases were reconstructed as “Ω” shaped double anastomosis, and the rest had closure of proximal stump with pancreaticojejunostomy at the distal. When compared to DP group, MSP had longer operation time (MSP, 228.6; DP, 186.1 min; p=0.000), and less intraoperative blood loss (MSP, 246.7; DP, 392.2 ML; p=0.002). There was no difference in overall morbidity, pancreatic fistula (MSP, 32.9%; DP, 45.3%), or hemorrhage (MSP, 6.5%; DP, 2.4%). However MSP demonstrated lower incidence of Grade A pancreatic fistula (MSP, 1.3%; DP, 11.3%, p=0.008). MSP showed no difference in post-operative hospital stay or reoperation rate. Thirty-day mortality was null in both groups. After a median follow-up of 21 months, MSP resulted in a lower risk of endocrine insufficiency than that of DP (MSP, 4.3%; DP, 24.7%, p=0.001) but no significant difference in exocrine failure. No recurrence of low-grade malignancies were detected during the follow-up.

CONCLUSIONS: MSP is a safe and effective treatment for selected lesions in neck and proximal body of pancreas with better longterm endocrine function.

Variations in medical oncology utilization practices by pancreatic cancer patients in a single payer health care system
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INTRODUCTION: Population-based studies in the United States of America have shown that pancreatic cancer (PC) has one of the lowest rates of cancer directed therapy among solid organ malignancies. Socio-economic factors, referral patterns and unequal access to health-care might be responsible. The main aim of this study was to assess PC directed therapy in a cohort of patients diagnosed with PC in Nova Scotia.

METHODS: A cohort of 1129 patients with PC was identified using the Provincial Cancer Registry over a 10-year period (2001-2010). Demographic, clinical and socio-economic data were extracted from the linkage of multiple administrative databases. Predictors of medical oncology healthcare utilization in PC patients were explored by multivariable regression analyses.