PANCREATODUODENECTOMY: BRAZILIAN PRACTICE PATTERNS

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**PANCREATODUODENECTOMY: BRAZILIAN PRACTICE PATTERNS***

*Duodenopancreatectomia: prática padrão do Brasil*

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**ABSTRACT - Background:** Pancreatoduodenectomy is a technically challenging surgical procedure with an incidence of postoperative complications ranging from 30% to 61%. The
CANCER OF THE PANCREATIC HEAD

- Fourth leading cause of death
- Surgical resection: potential of cure
- PD: Technically challenging procedure
- Mortality: 3-5%
- Morbidity: 30-61%
TECHNICAL FACTORS

- Complications
- High level of experience
- Centralization
- Practice patterns
  - Resection
  - Reconstruction
- Heterogeneity (Brazil)
The aim of this study was to analyze the Brazilian practice patterns for pancreateoduodenectomy.
METHOD

- Brazilian Chapter - IHPBA
- Questionnaire - 60 institutions
  - Specific training
  - Experience
  - Technical aspects
  - Clinical aspects
- Returned - 52 (86.7%)
RESULTS

- NORTH 3.9%
- NORTHEAST 19.2%
- CENTER-WEST 7.7%
- SOUTHEAST 48.0%
- SOUTH 21.2%

Torres et al. Arq Bras Cir Dig 2017;30(3).
TABLE 1 - Characteristics of study population (n and %)

<table>
<thead>
<tr>
<th>Specialty/Training</th>
<th>Experience</th>
<th>Number of PDs</th>
<th>DPs em 2015</th>
<th>Practice setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery 4 (7.7)</td>
<td>Practice (PD) in years</td>
<td>1–20 2 (3.9)</td>
<td>1–5 6 (11.5)</td>
<td>Public (academic/university) 3 (5.8)</td>
</tr>
<tr>
<td>GI Surgery 8 (15.4)</td>
<td>0–5 0 (0)</td>
<td>21–50 12 (23.1)</td>
<td>6–10 14 (27.0)</td>
<td>Public (non-academic/non-university) 3 (5.8)</td>
</tr>
<tr>
<td>Surgical Oncology 9 (17.3)</td>
<td>6–10 9 (17.3)</td>
<td>51–100 16 (30.8)</td>
<td>11–15 9 (17.3)</td>
<td>Public and private 36 (69.2)</td>
</tr>
<tr>
<td>Hepato-pancreatobiliary 30 (57.7)</td>
<td>11–15 13 (25.0)</td>
<td>101–150 6 (11.5)</td>
<td>16–20 8 (15.4)</td>
<td>Private only 10 (19.2)</td>
</tr>
<tr>
<td>Pancreatic Surgery 1 (1.9)</td>
<td>16–20 12 (23.1)</td>
<td>151–200 2 (3.9)</td>
<td>21–25 6 (11.5)</td>
<td></td>
</tr>
<tr>
<td>&gt;20 18 (34.6)</td>
<td></td>
<td>201–300 7 (13.4)</td>
<td></td>
<td>&gt; 300 7 (13.4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&gt; 30 6 (11.5)</td>
</tr>
</tbody>
</table>

Torres et al. Arq Bras Cir Dig 2017;30(3).
FIGURE 1 – Laparoscopic pancreatoduodenectomy (%) of their cases

Torres et al. Arq Bras Cir Dig 2017;30(3).
FIGURE 2 – Type of resection (%)
FIGURE 3 – Type of lymphadenectomy performed in Brazil (%)

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FIGURE 4 – Type of reconstruction (stomach or jejunum) (%)
FIGURE 5 – Type of pancreatojejunostomy (single or Roux) (%)
FIGURE 6 – Technical aspects (%)
MODIFIED TECHNIQUE
STENT INTO THE PANCREATIC DUCT

- INTERNAL 50.0%
- EXTERNAL 3.9%
- NO STENT 46.1%

Torres et al. Arq Bras Cir Dig 2017;30(3).
FIGURE 7 – Maneuver to protect the anastomosis (%)
FIGURE 8 – Route of gastric reconstruction (%)
BRAUN ENTEROENTEROSTOMY

- YES 11.5%
- NO BRAUN 88.5%

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FIGURE 9 – Prophylactic abdominal drainage (%)

Torres et al. Arq Bras Cir Dig 2017;30(3).
FIGURE 10 – Early feeding (%)

Torres et al. Arq Bras Cir Dig 2017;30(3).
São Luís

Thanks!