39ª JACAD
Jornada de Atualização em Cirurgia do Aparelho Digestivo

Dias 03 e 04 Outubro | 2025

Centro de Eventos AMRIGS
Porto Alegre I RS

- Congresso CBC RS
- 1° Encontro dos Residentes de Cirurgia Geral do RS
- 5º Simpósio das Ligas Acadêmicas de Cirurgia do RS

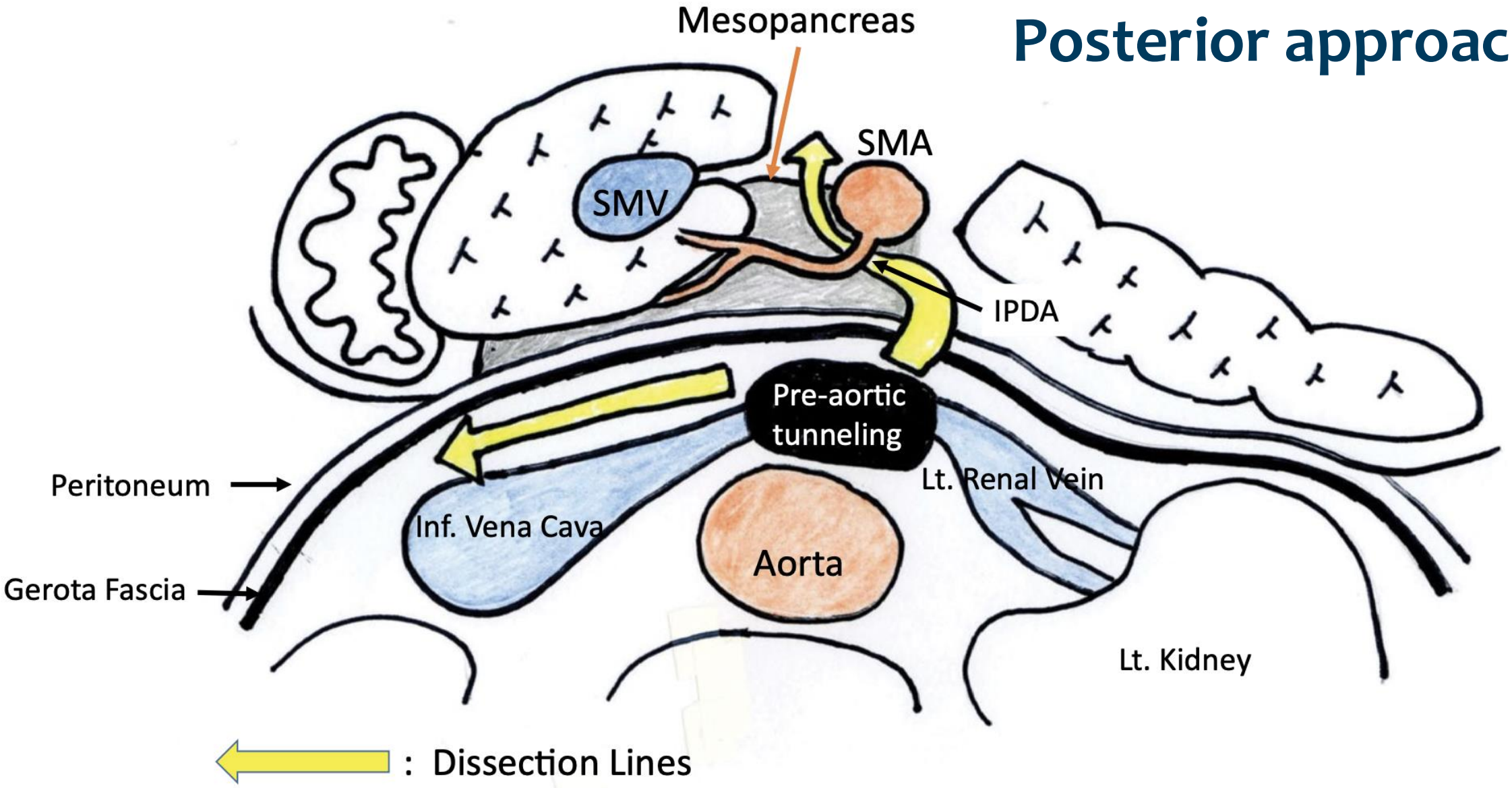
Realização
CBC
Colégio Brasileiro de Cirurgiões
Capítulo Rio Grande do Sul

Organização
office EVENTOS

Porque o mesopâncreas deve ser ressecado na duodenopancreatectomia

Orlando Jorge M Torres
Serviço de Cirurgia do Aparelho Digestivo
Unidade Hepatopancreatobiliar - UFMA

Posterior approach



Hirota M, et al. J Pancreas 2017; 18:245-5

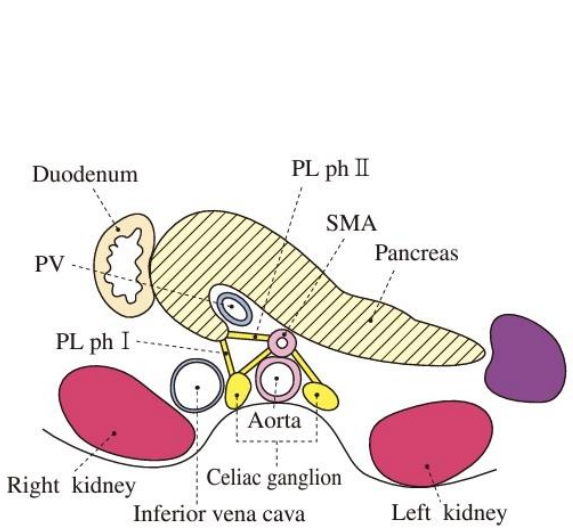


Fig. 3a Pancreatic nerve plexuses (cross-sectional diagram)

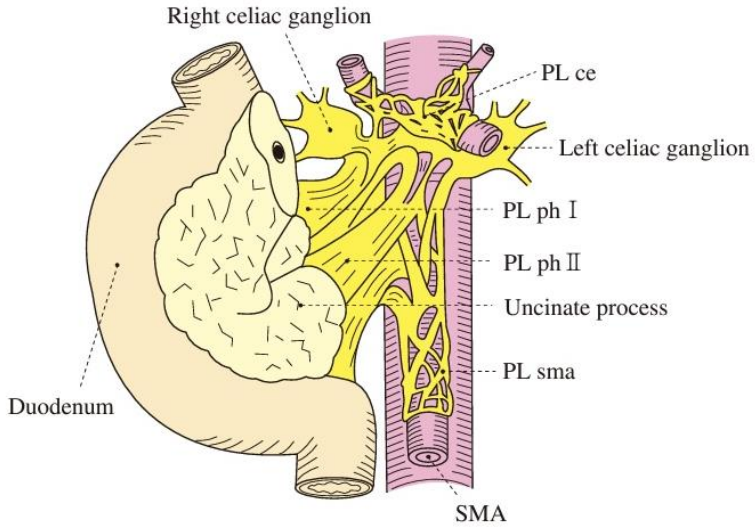
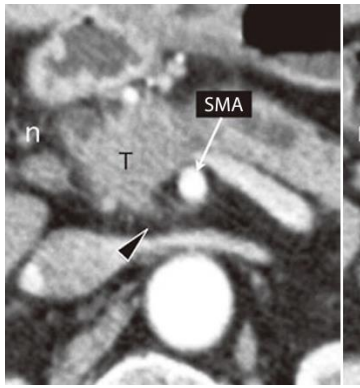
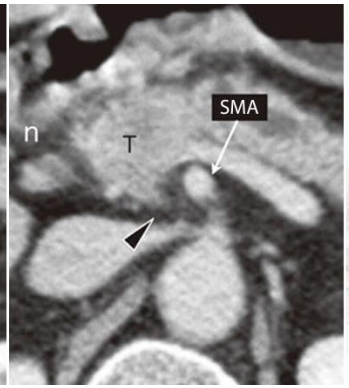


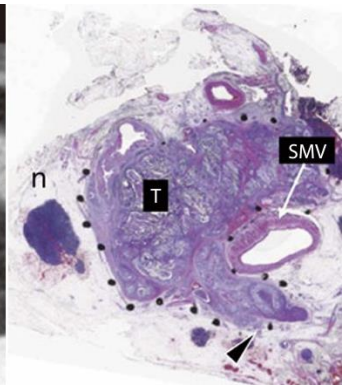
Fig. 3b Extrapancreatic nerve plexuses

PLph I: pancreatic head nerve plexus I
PLsma: superior mesenteric nerve plexus
PLhdl: hepatoduodenal ligament nerve plexus
PLce: celiac plexus

PLph II: pancreatic head nerve plexus II
PLcha: common hepatic artery nerve plexus
PLspa: splenic artery nerve plexus







膵癌取扱い規約（英語版 第4版）
［膵癌取扱い規約 第7版 準拠］

Classification of Pancreatic Carcinoma

Japan Pancreas Society
Fourth English Edition

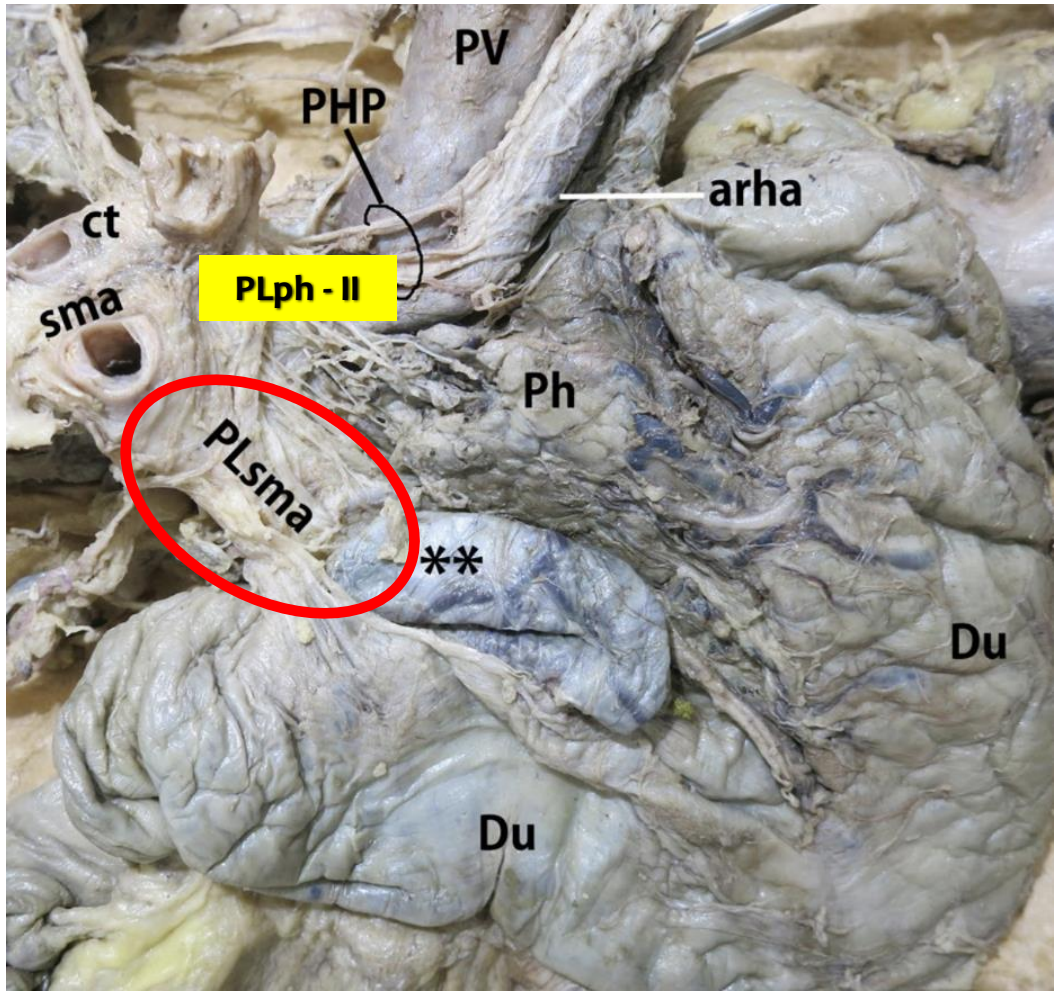
Kanehara & Co., Ltd.

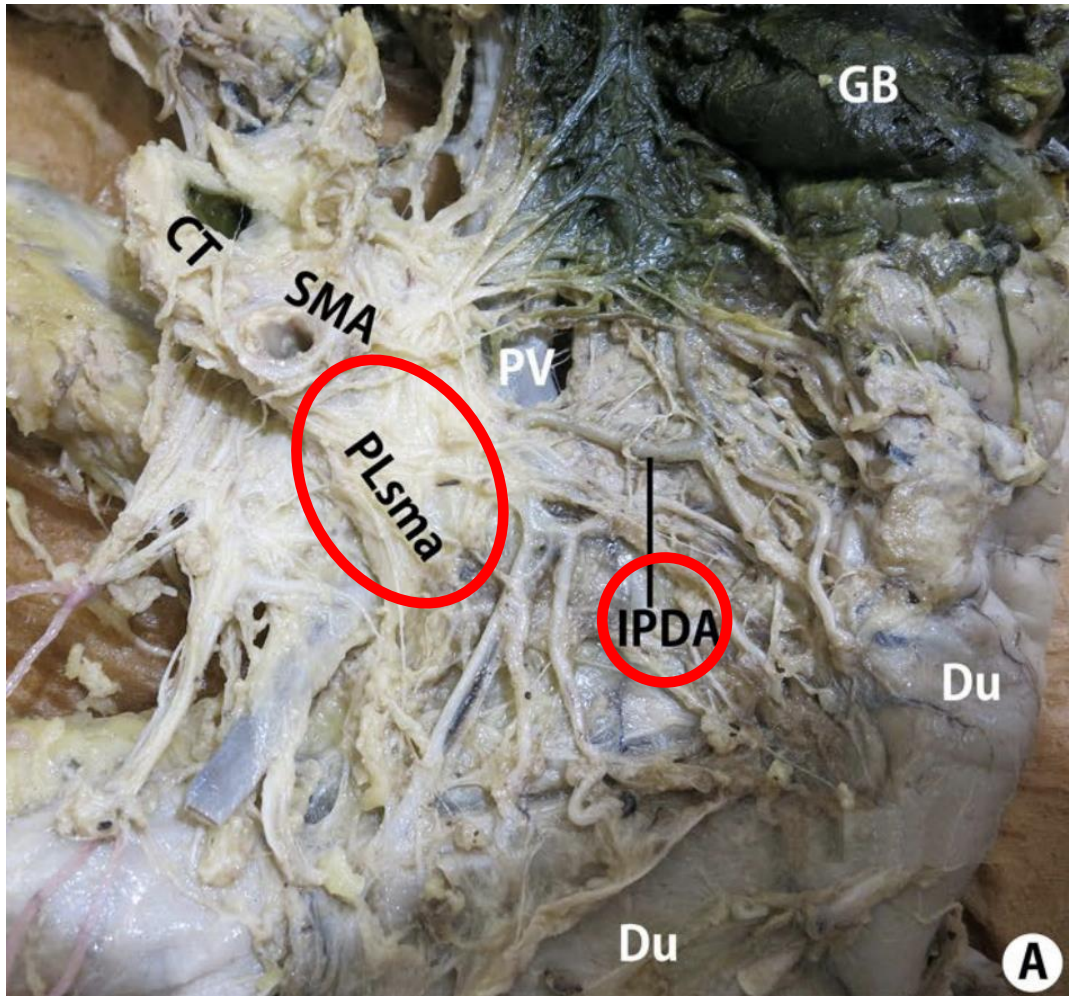
Japan Pancreas Society – Fourth English Edition, 2017

Surgical and Radiologic Anatomy (2020) 42:1501–1508
https://doi.org/10.1007/s00276-020-02547-y

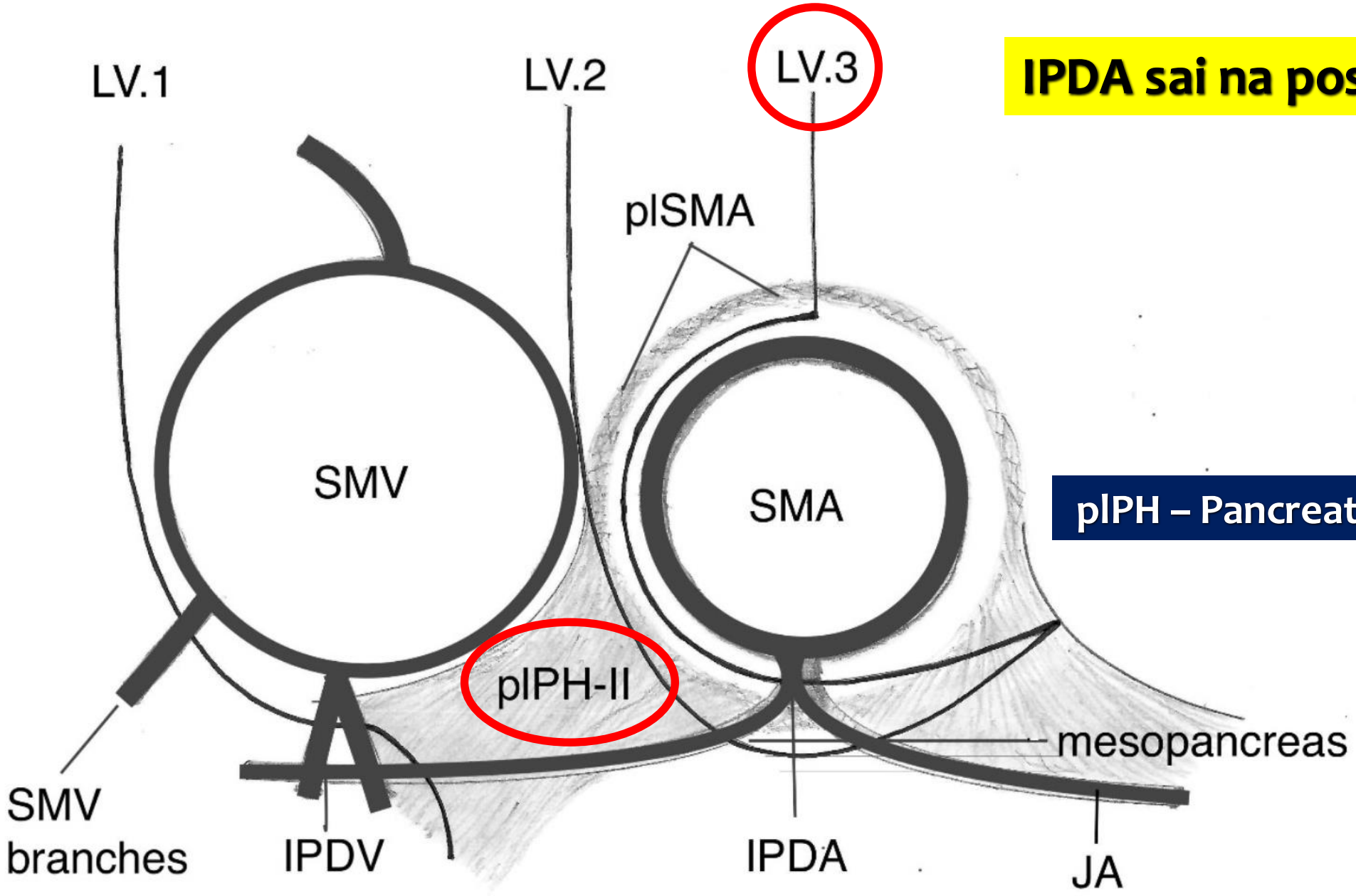
ORIGINAL ARTICLE

The mesopancreas and pancreatic head plexus: morphological, developmental, and clinical perspectives





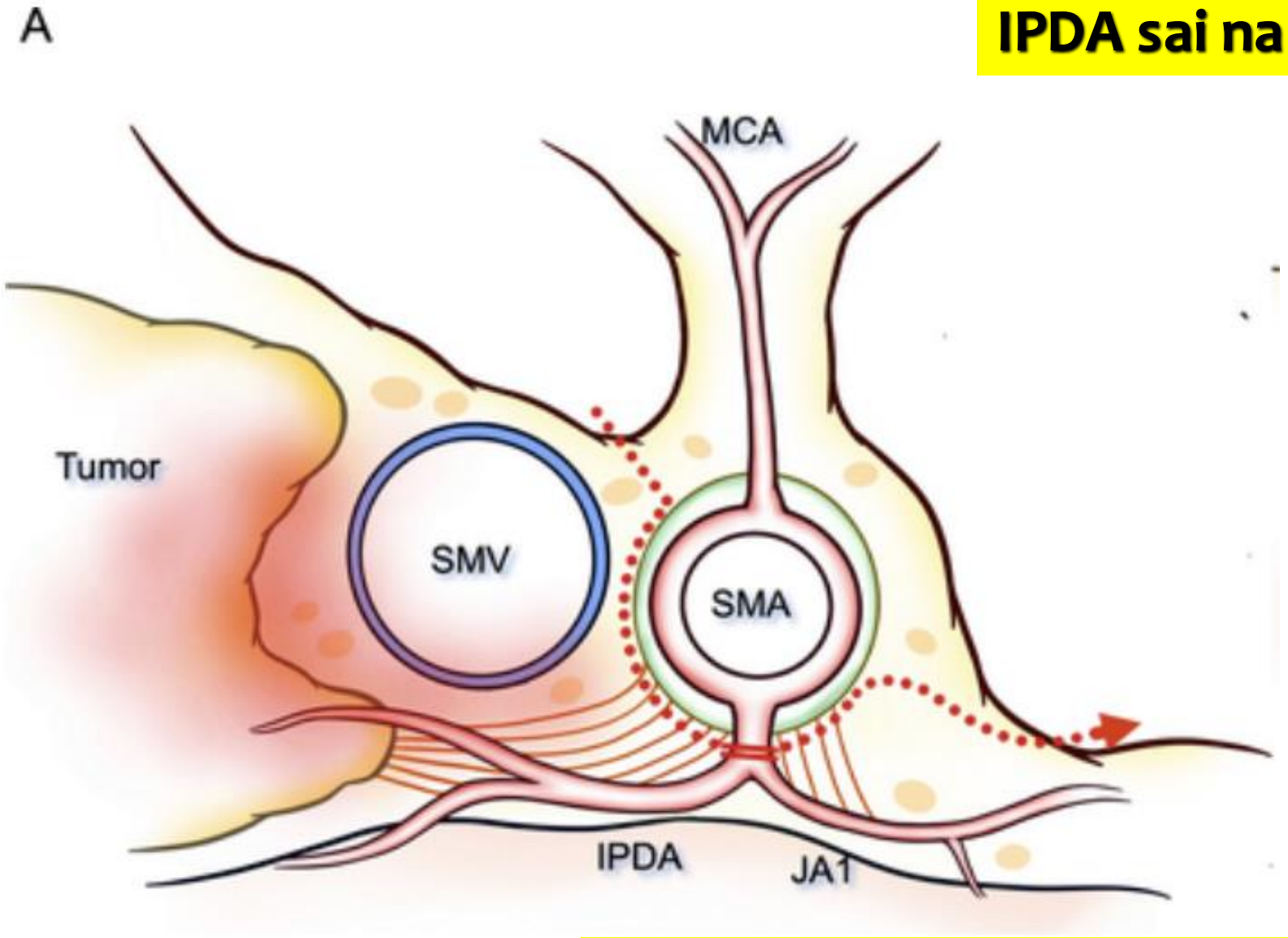
IPDA sai na posição de 6h



plPH – Pancreatic head plexus

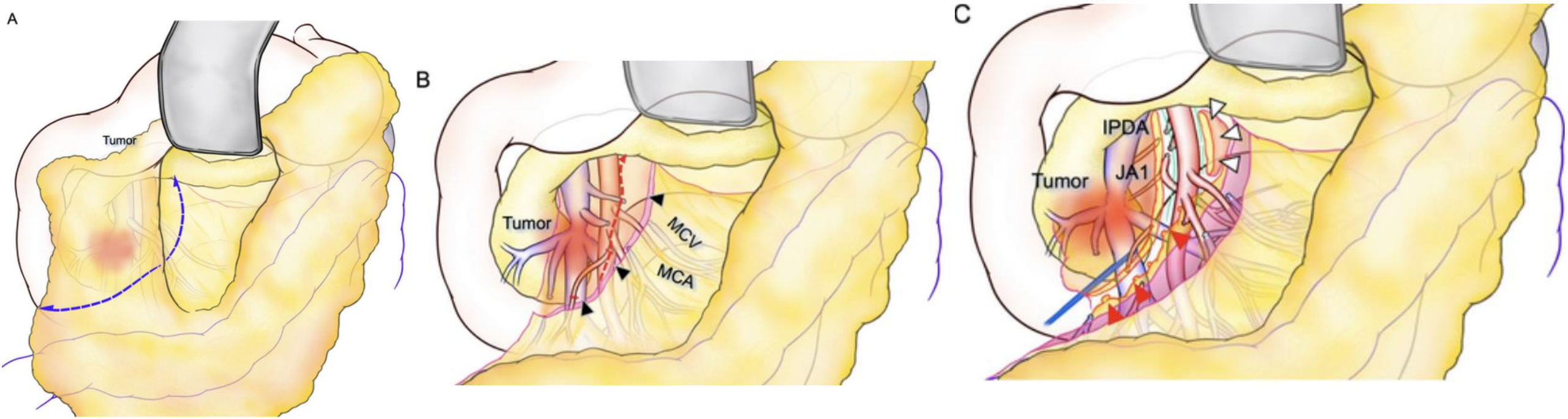
Olakowski M, et al. J Oncol 2021

IPDA sai na posição de 6h



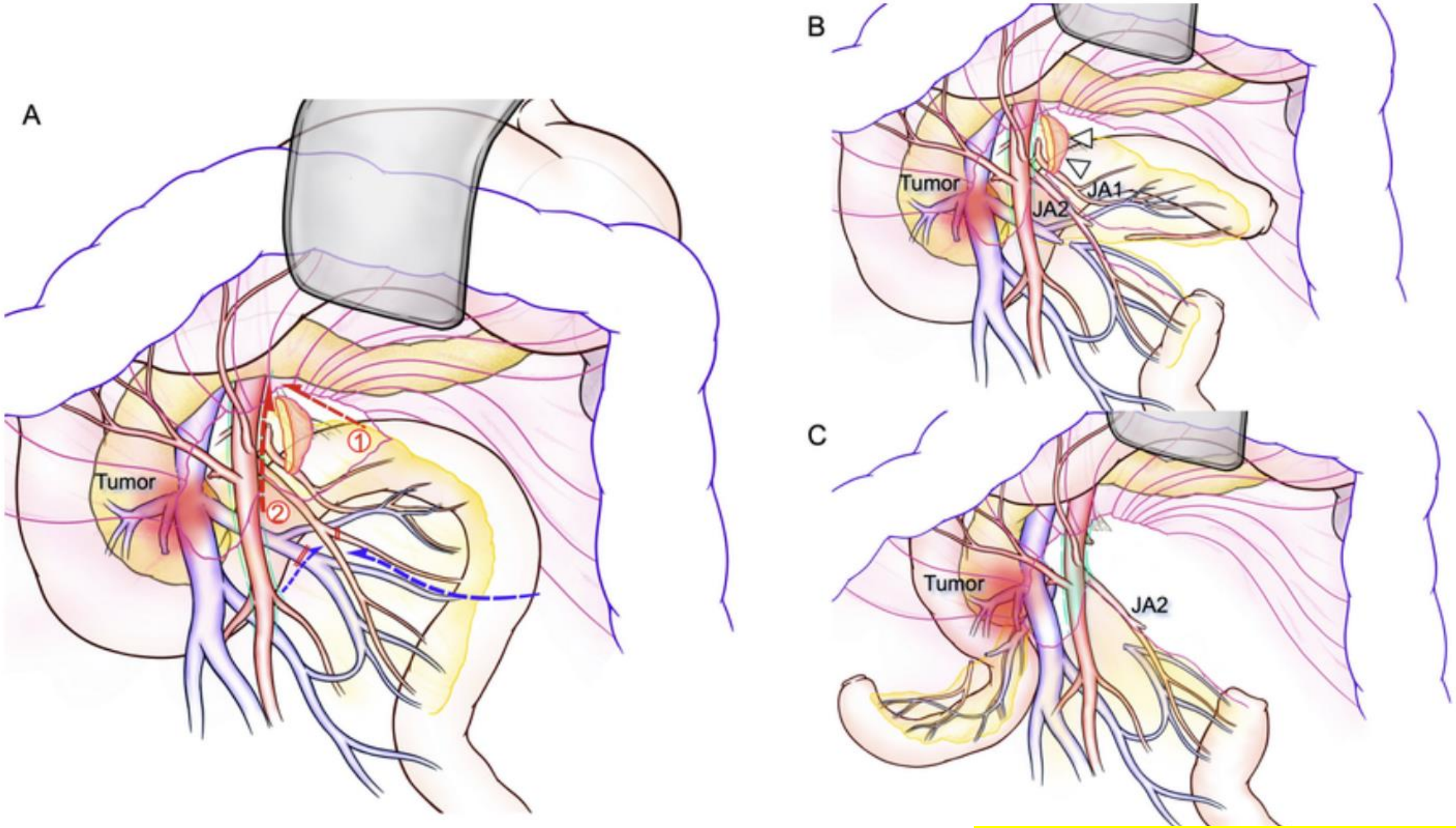
EPICENTRO DA DUODENOPANCREATECTOMIA

Ono Y, et al. Langenbecks Arch Surg 2023;408(1):422



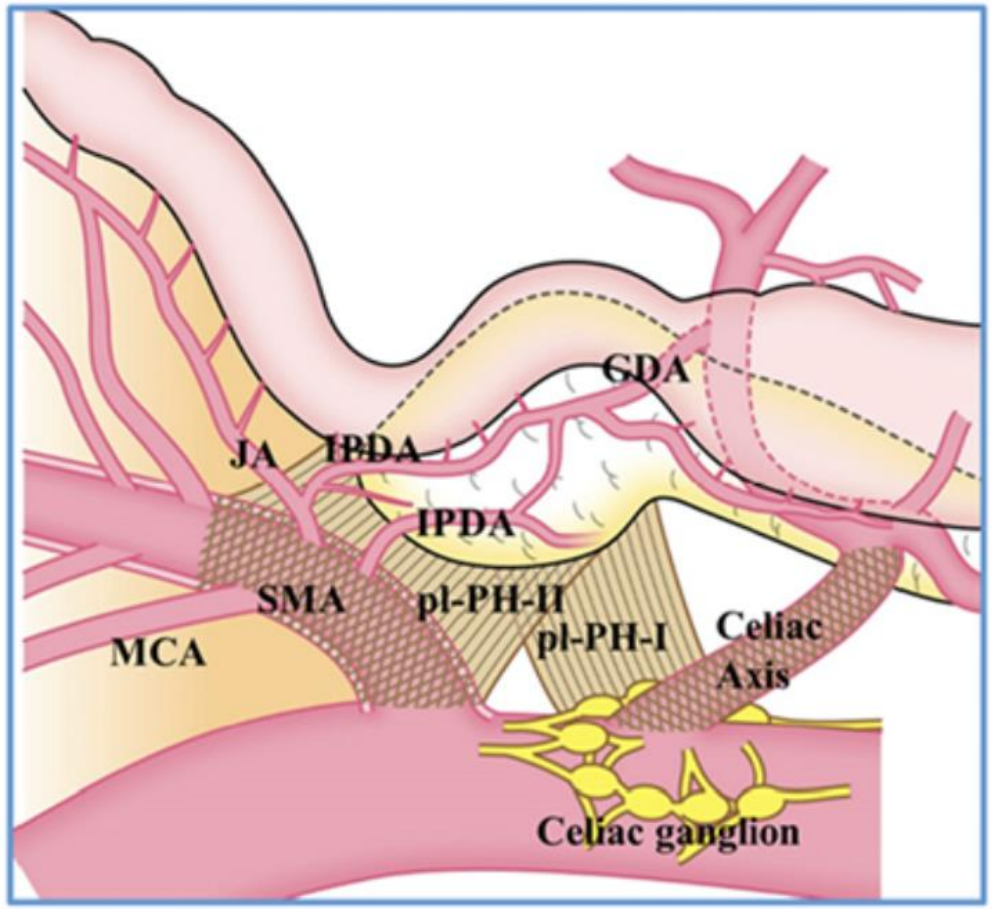
MESENTERIC APPROACH

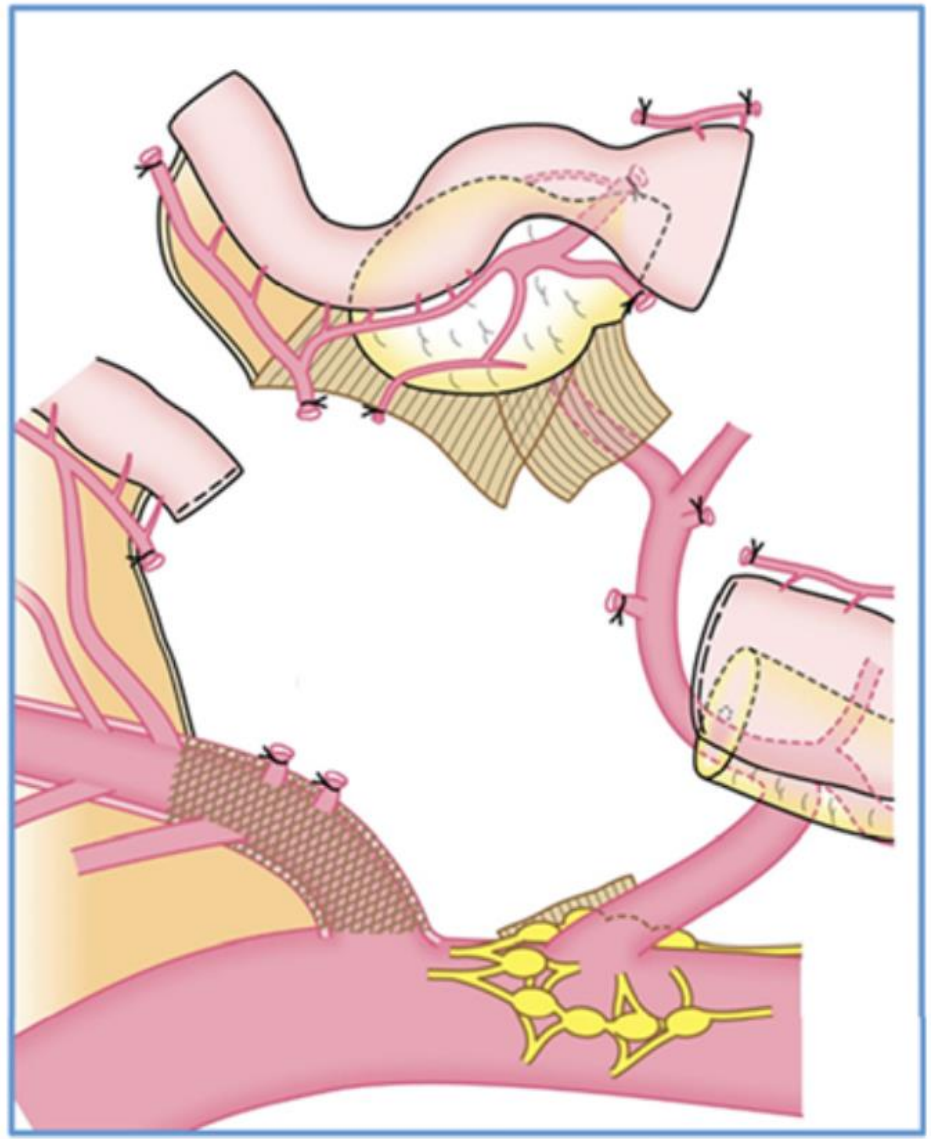
Ono Y, et al. Langenbecks Arch Surg 2023;408(1):422



Ono Y, et al. Langenbecks Arch Surg 2023;408:422

MESENTERIC APPROACH



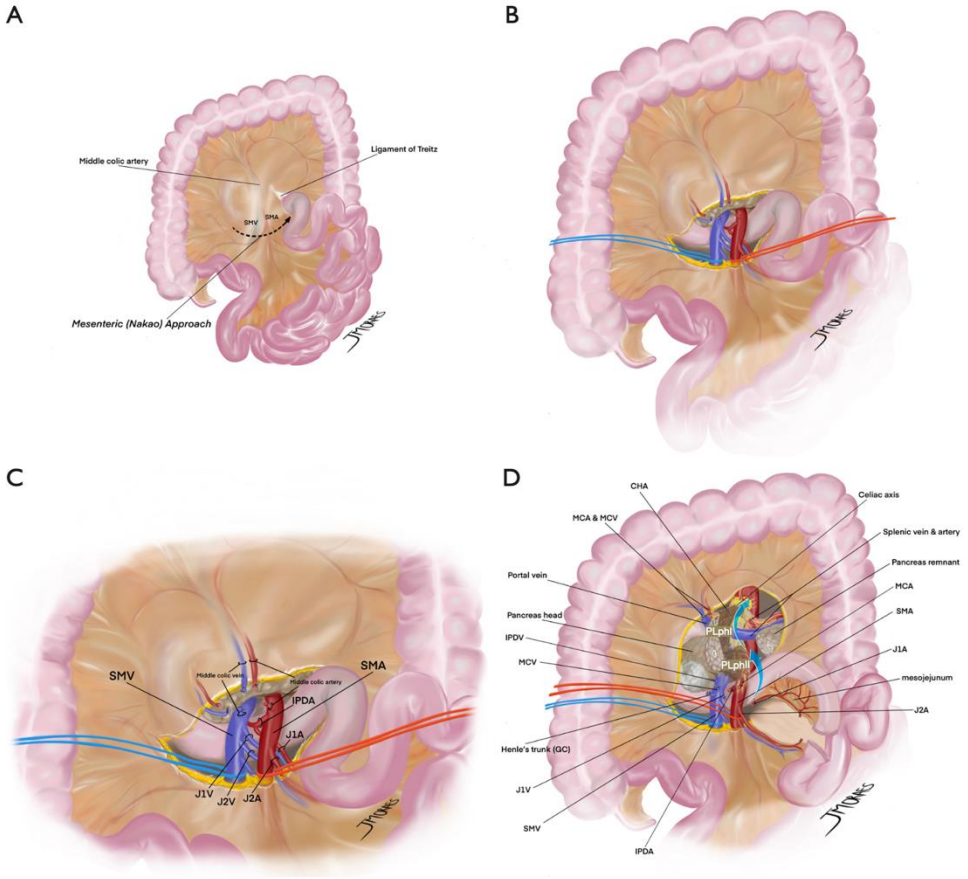


Inoue Y, et al. J Gastrointest Surg 2016

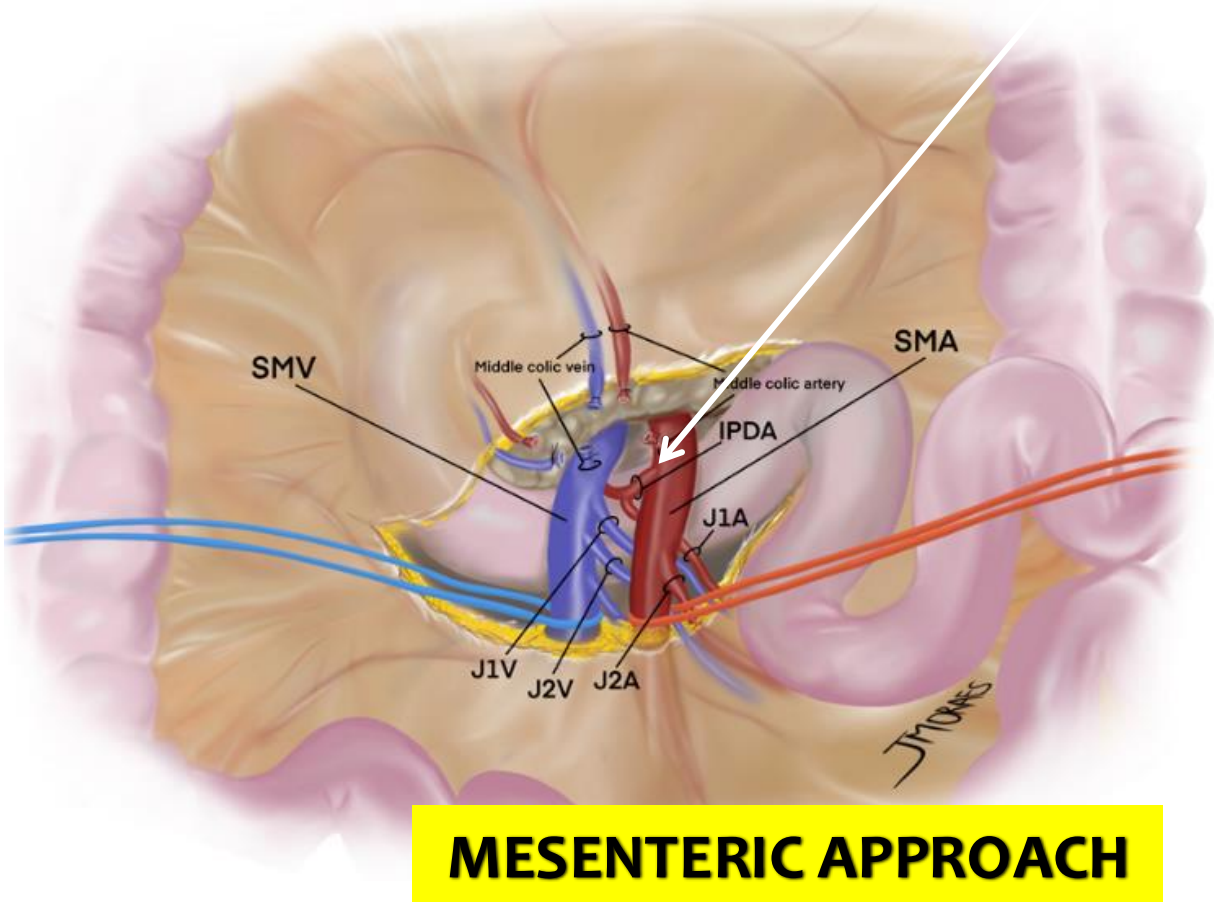
Review Article

A more radical perspective on surgical approach and outcomes in pancreatic cancer—a narrative review

Eduardo de Souza M. Fernandes[1,2,3], Felipe Pedreira T. de Mello[1,2], Eduardo Pinho Braga[1], Gabrielle Oliveira de Souza[1], Ronaldo Andrade[1,2], Leandro Savattone Pimentel[1,2], Camila Liberato Girão[1,2], Munique Siqueira[1,2], José Maria A. Moraes-Junior[6,7], Romulo Varella de Oliveira[4], Nicolas Goldaracena[5], Orlando Jorge M. Torres[6,7]

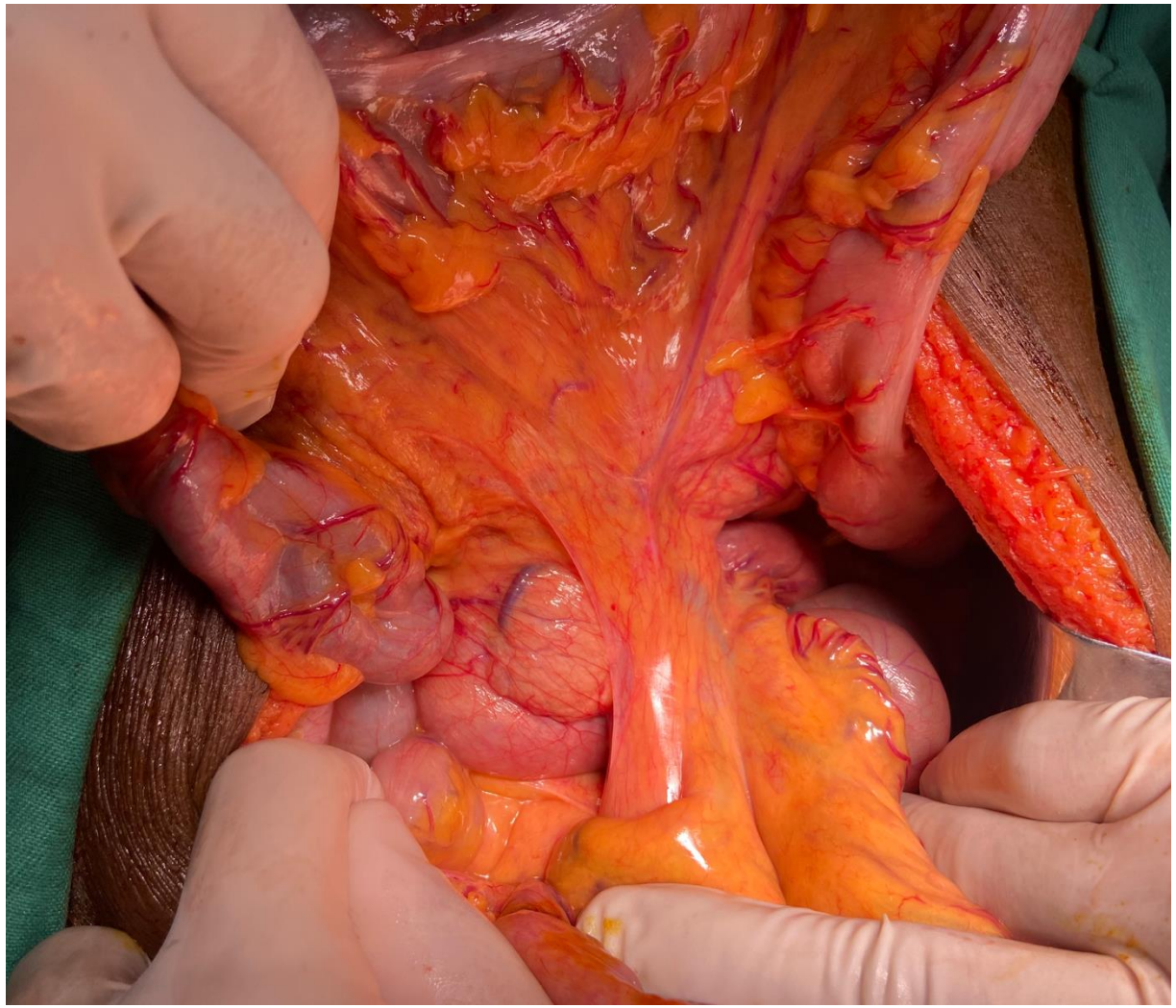


Inferior pancreatoduodenal artery (IPDA)



MESENTERIC APPROACH

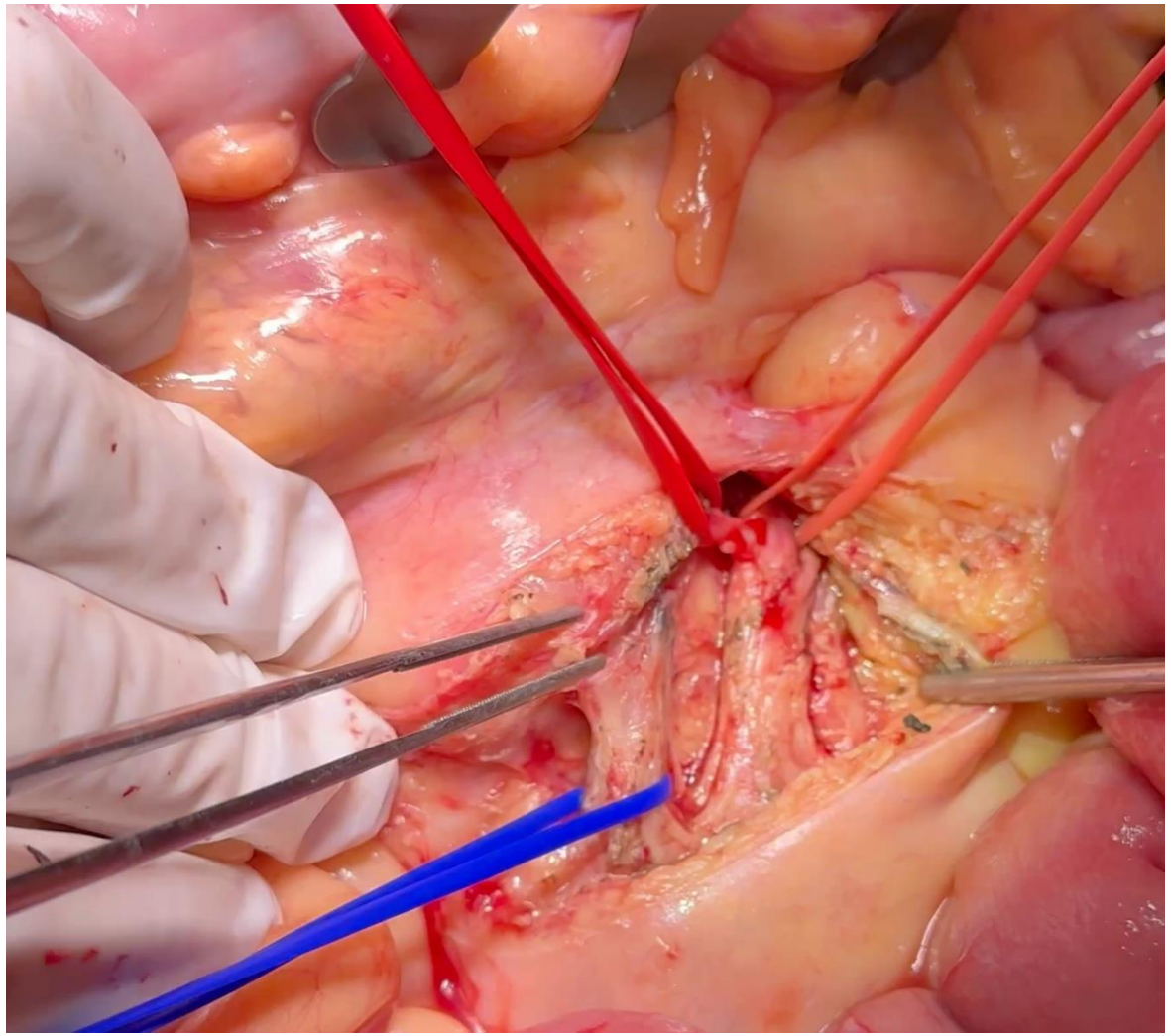
Fernandes ESM, et al. J Gastrointest Oncol 2023

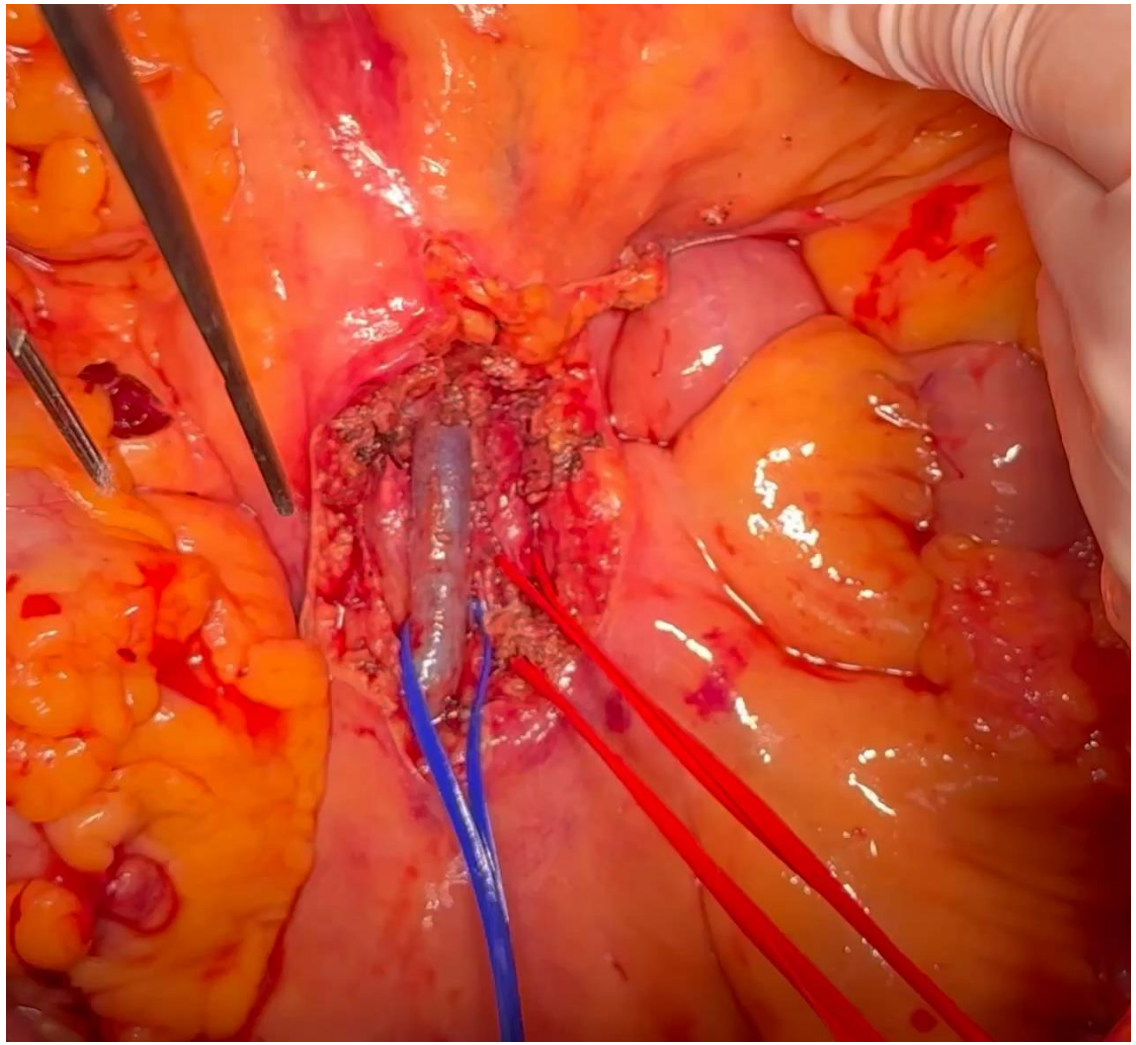


Infracolic approach

MESENTERIC APPROACH

INFRACOLIC APPROACH





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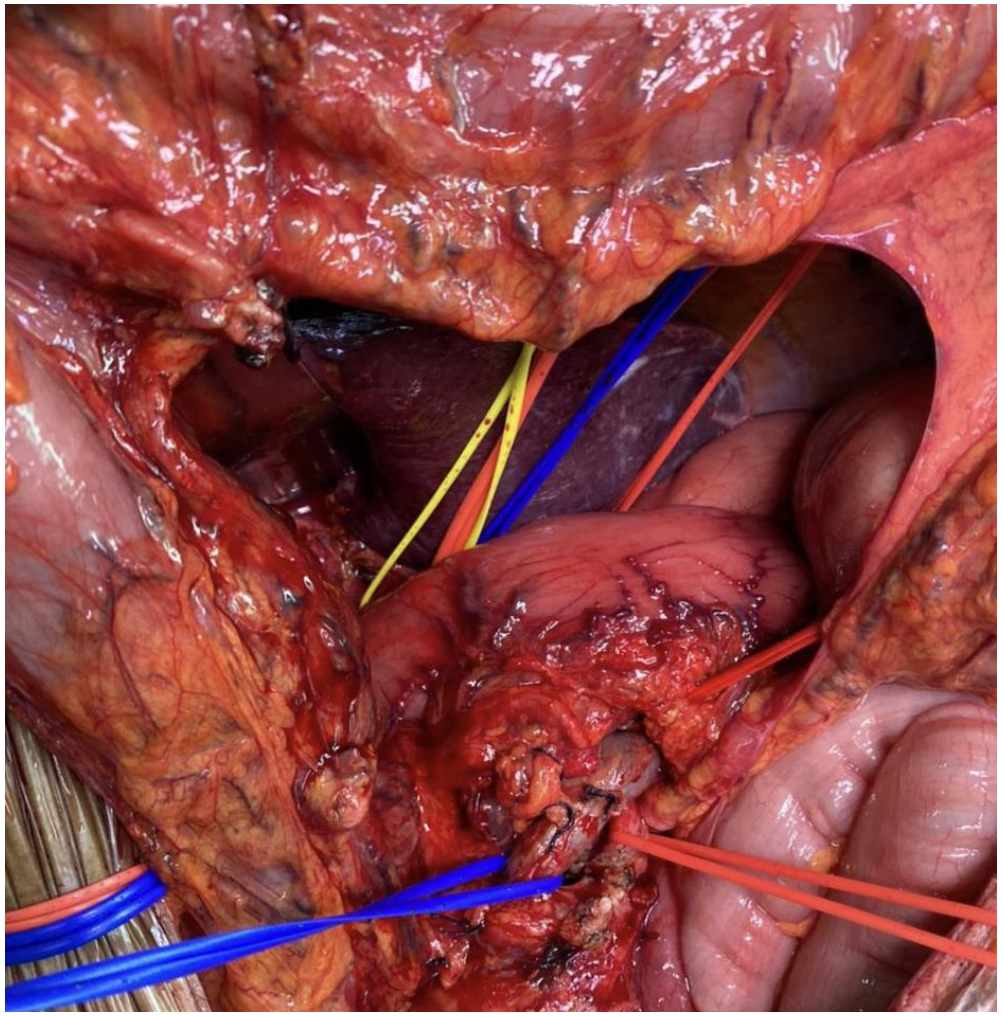
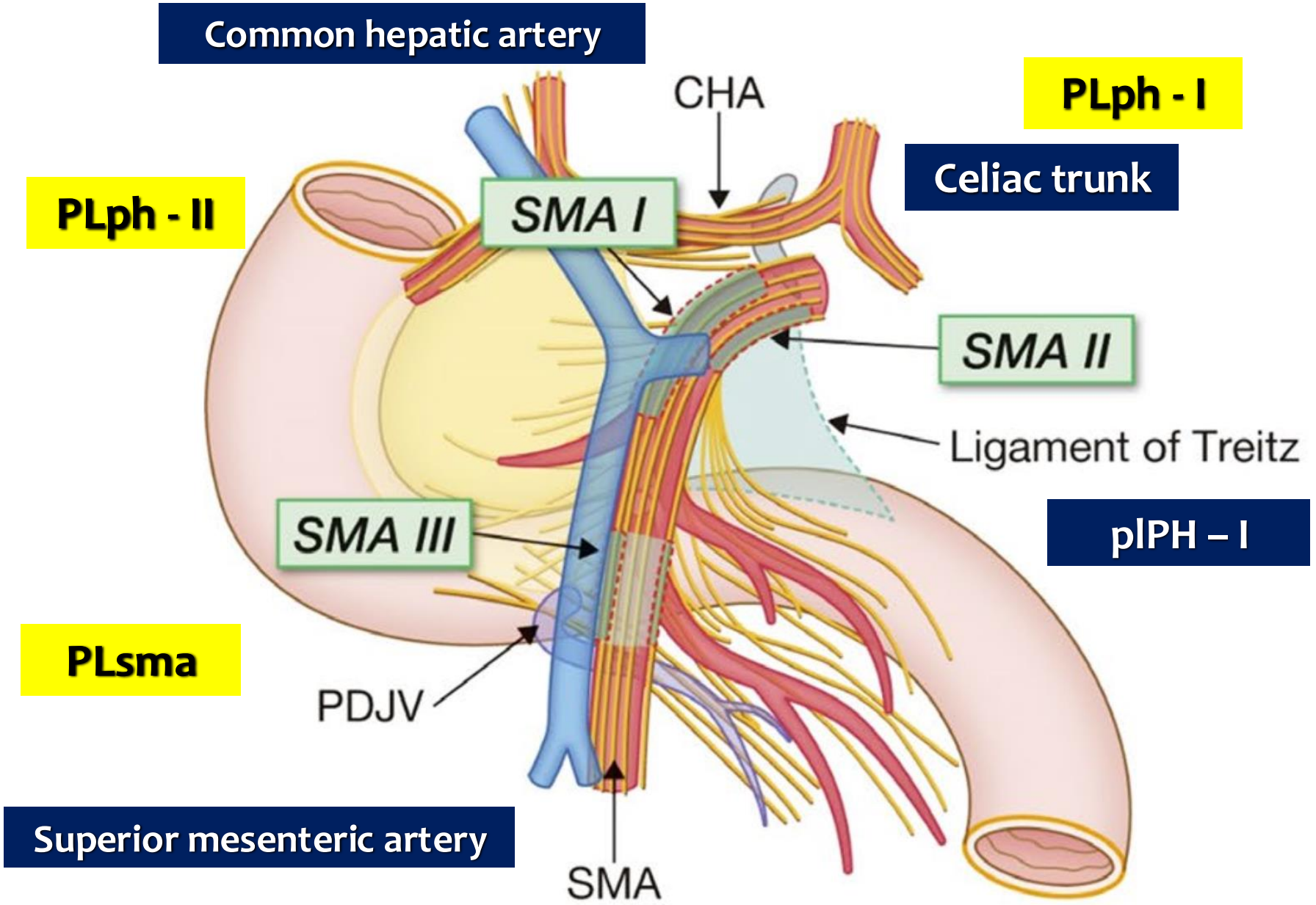


Infracolic approach

MESENTERIC APPROACH

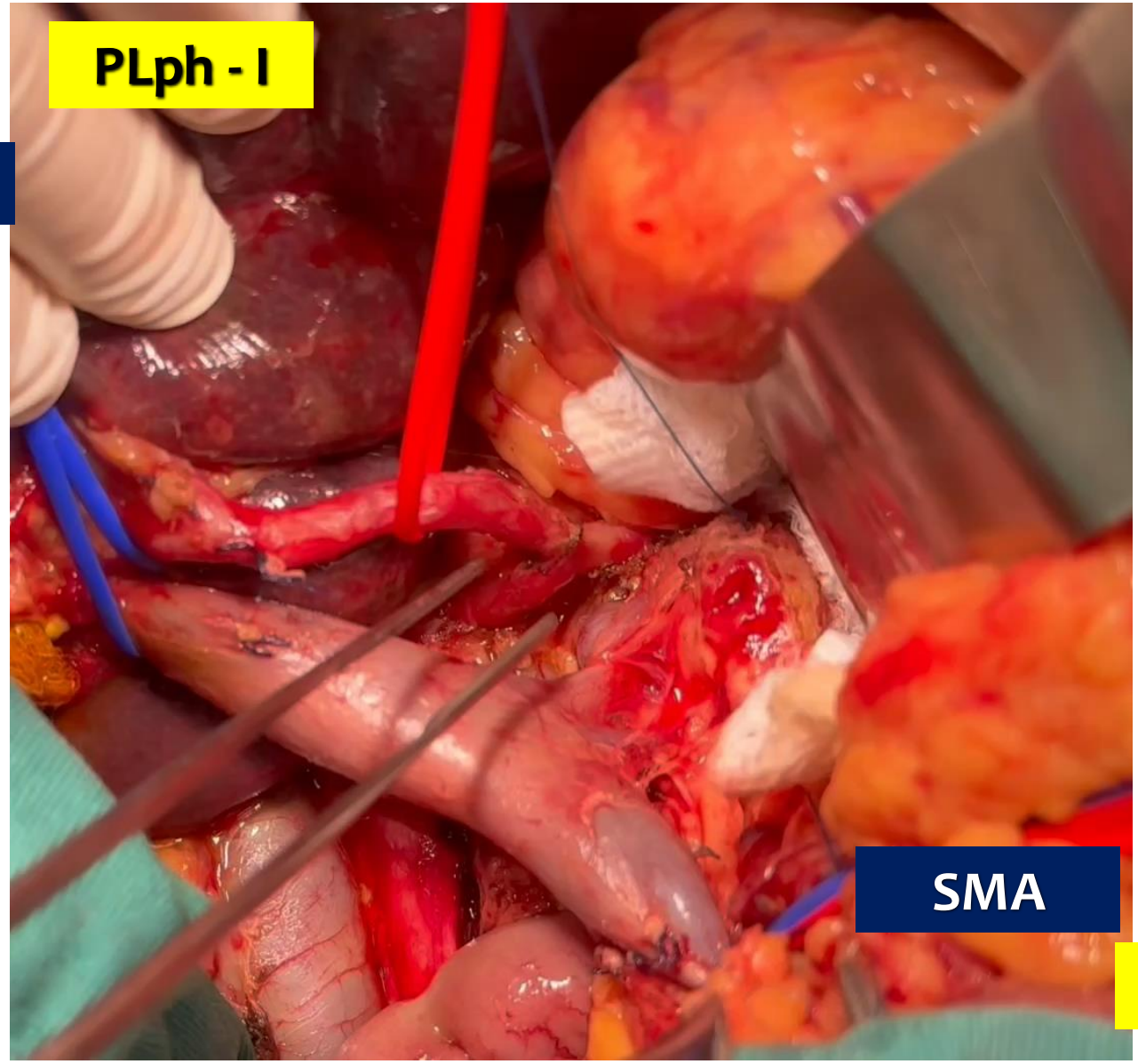


Nagakawa Y, et al. J Hepatobiliary Pancreat Sci. 2020;27:342–51

CELIAC TRUNK

PLph - I

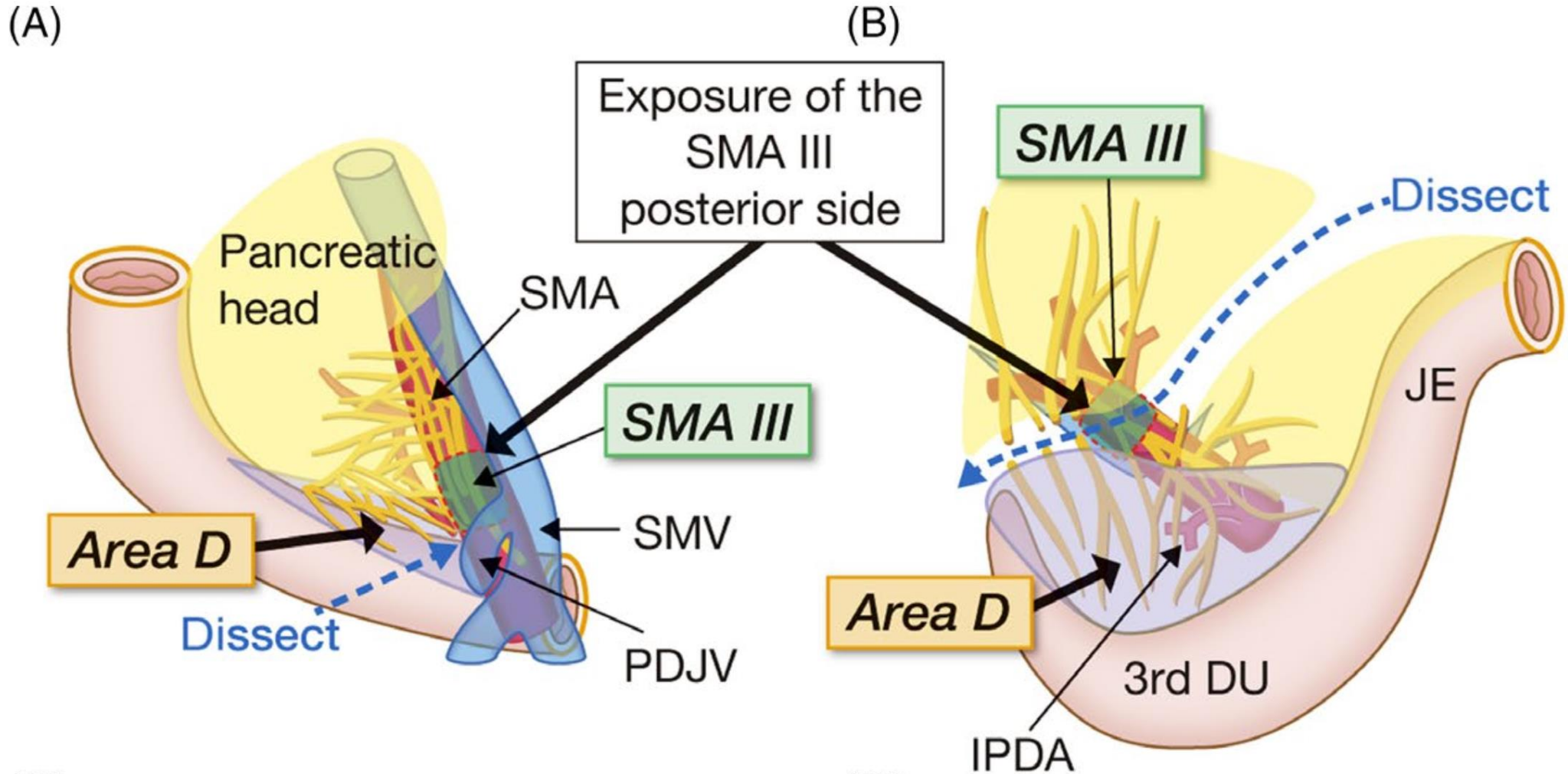
PLph - II



SMA

PLsma

SANTO ANDRÉ – SP



Nagakawa Y, et al. J Hepatobiliary Pancreat Sci. 2020;27:342–51

Annals of Surgical Oncology **15**(6):1651–1660
DOI: 10.1245/s10434-008-9839-8

Most Pancreatic Cancer Resections are R1 Resections

Irene Esposito, MD,[1,3] Jörg Kleeff, MD,[2,4] Frank Bergmann, MD,[1] Caroline Reiser, MD,[2,4] Esther Herpel, MD,[1] Helmut Friess, MD,[2,4] Peter Schirmacher, MD,[1] and Markus W. Büchler, MD[2]

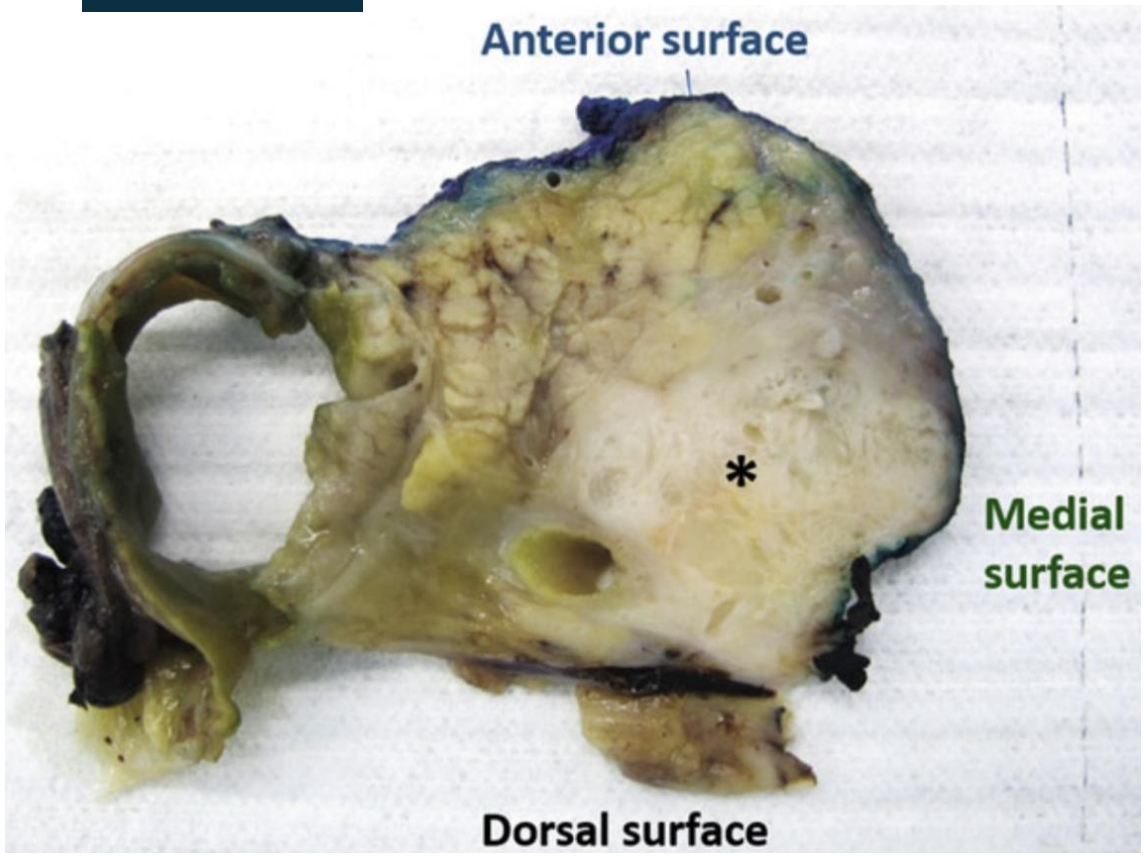
TABLE 3. *Tumor margin characteristics of 111 consecutive macroscopic complete resections for pancreatic ductal adenocarcinoma (2005–2006)*

Characteristic	Value, n (%)
R classification	
R0	27 (24%)
R1	84 (76%)
RM involvement	
Posterior	39 (47%)
Medial	57 (68%)
Anterior surface	8 (10%)
Superior	0
Transection (pancreas)	3 (4%)
Bile duct	4 (5%)
Stomach/duodenum	3 (4%)
Number of margins	
1	56 (68%)
2	22 (26%)
3 or more	5 (6%)
Type of involvement	
Direct extension	78 (93%)
Locoregional spreading	6 (7%)

RM, resection margin.

Medial margin: Mesopancreas

2008



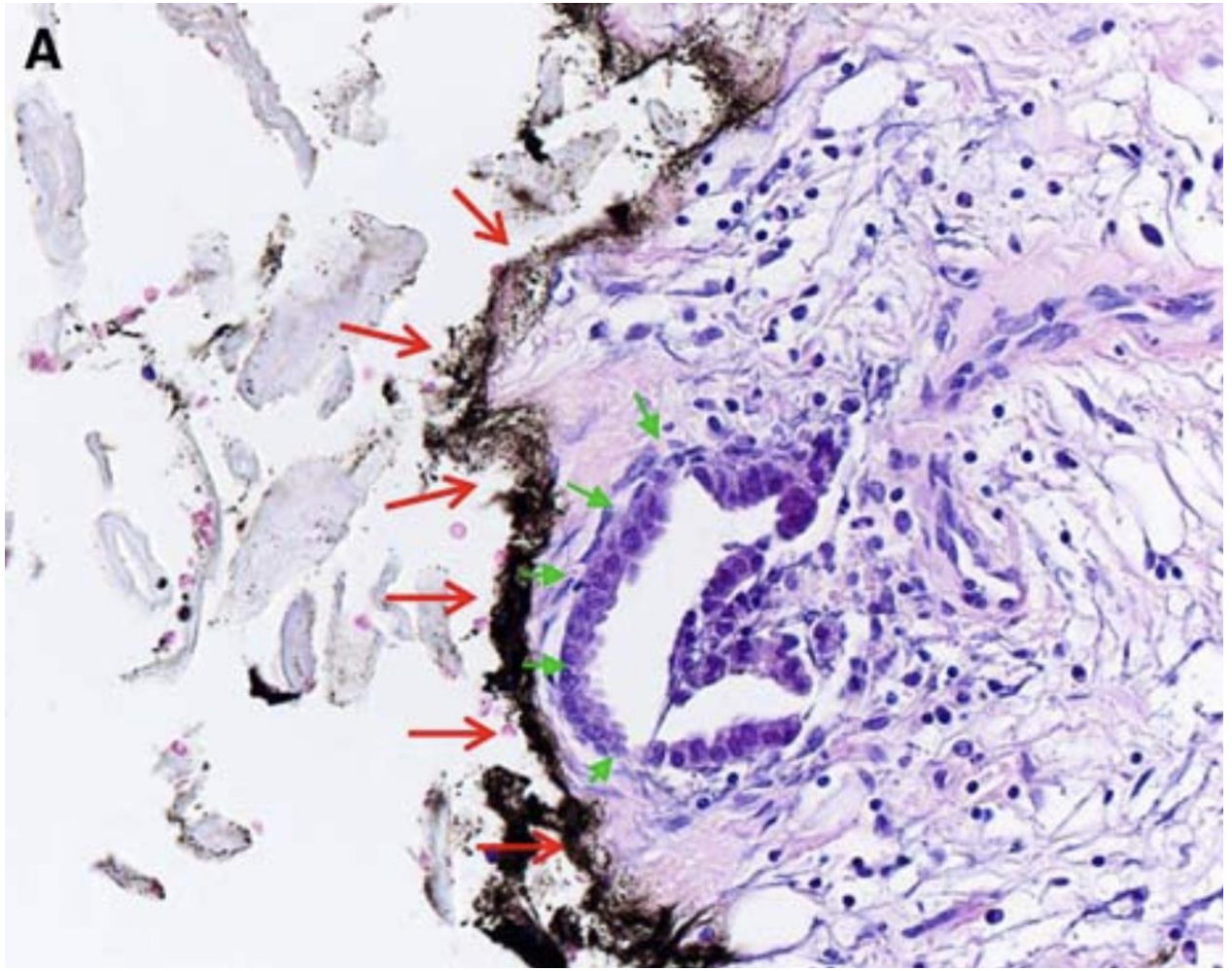
Irene Esposito - Heidelberg (Germany)

Esposito I, et al. Ann Surg Oncol 2008; 15:1651–60

Annals of Surgical Oncology **15**(6):1651–1660
DOI: 10.1245/s10434-008-9839-8

Most Pancreatic Cancer Resections are R1 Resections

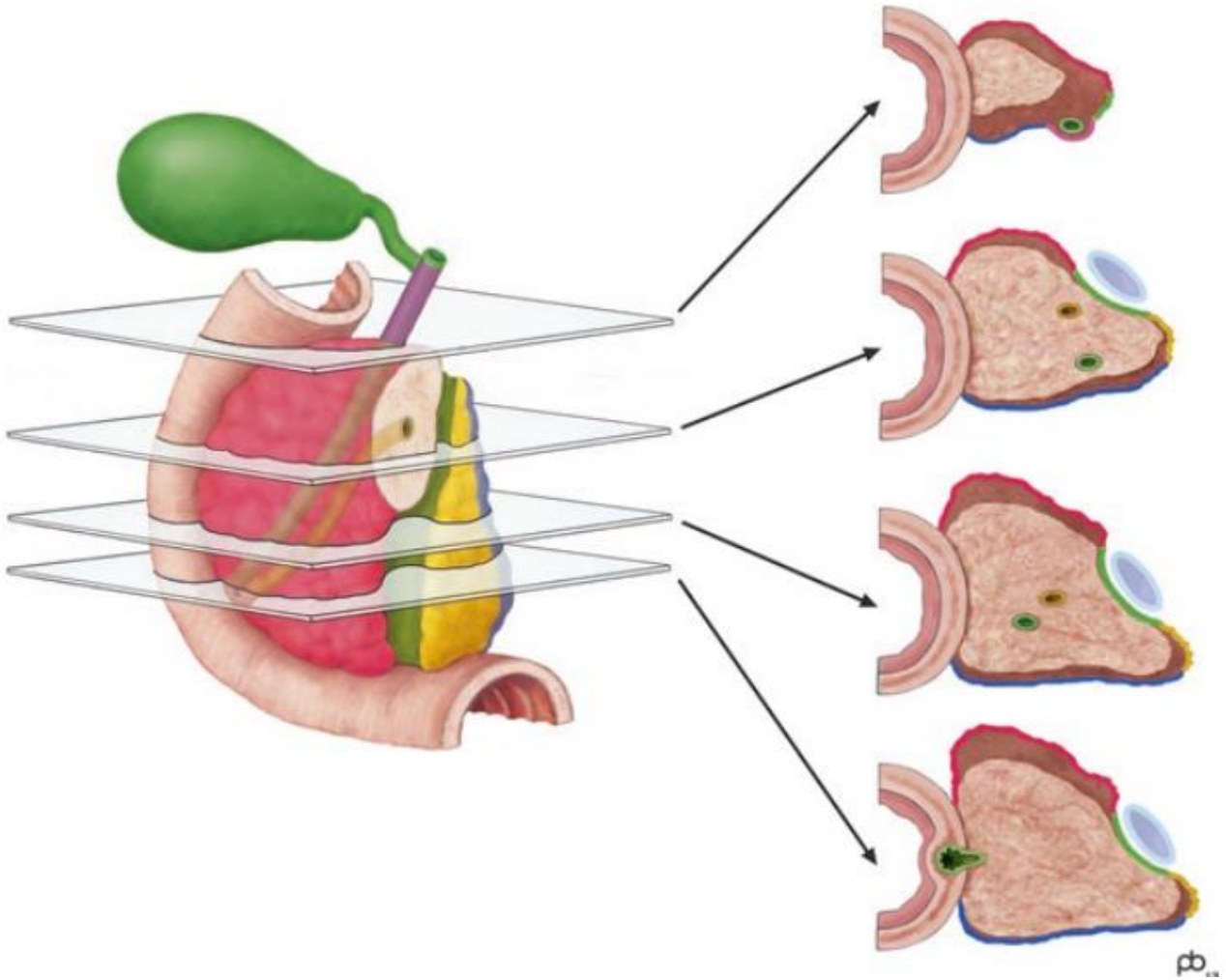
Irene Esposito, MD,[1,3] Jörg Kleeff, MD,[2,4] Frank Bergmann, MD,[1] Caroline Reiser, MD,[2,4] Esther Herpel, MD,[1] Helmut Friess, MD,[2,4] Peter Schirmacher, MD,[1] and Markus W. Büchler, MD[2]

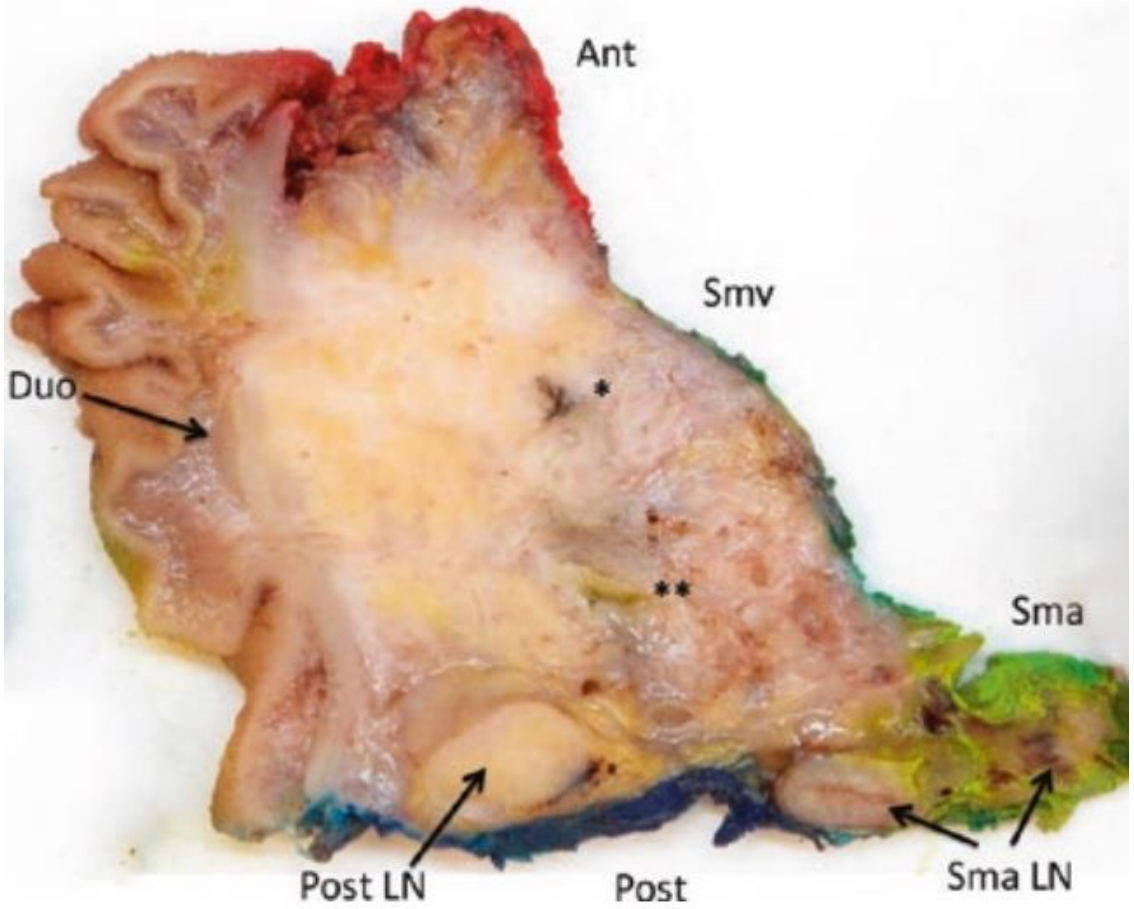


R1 – Margem ≤ 1 mm
Seta verde – Neoplasia
Seta vermelha - margem

Esposito I, et al. Ann Surg Oncol 2008; 15:1651–60

Mesopancreas

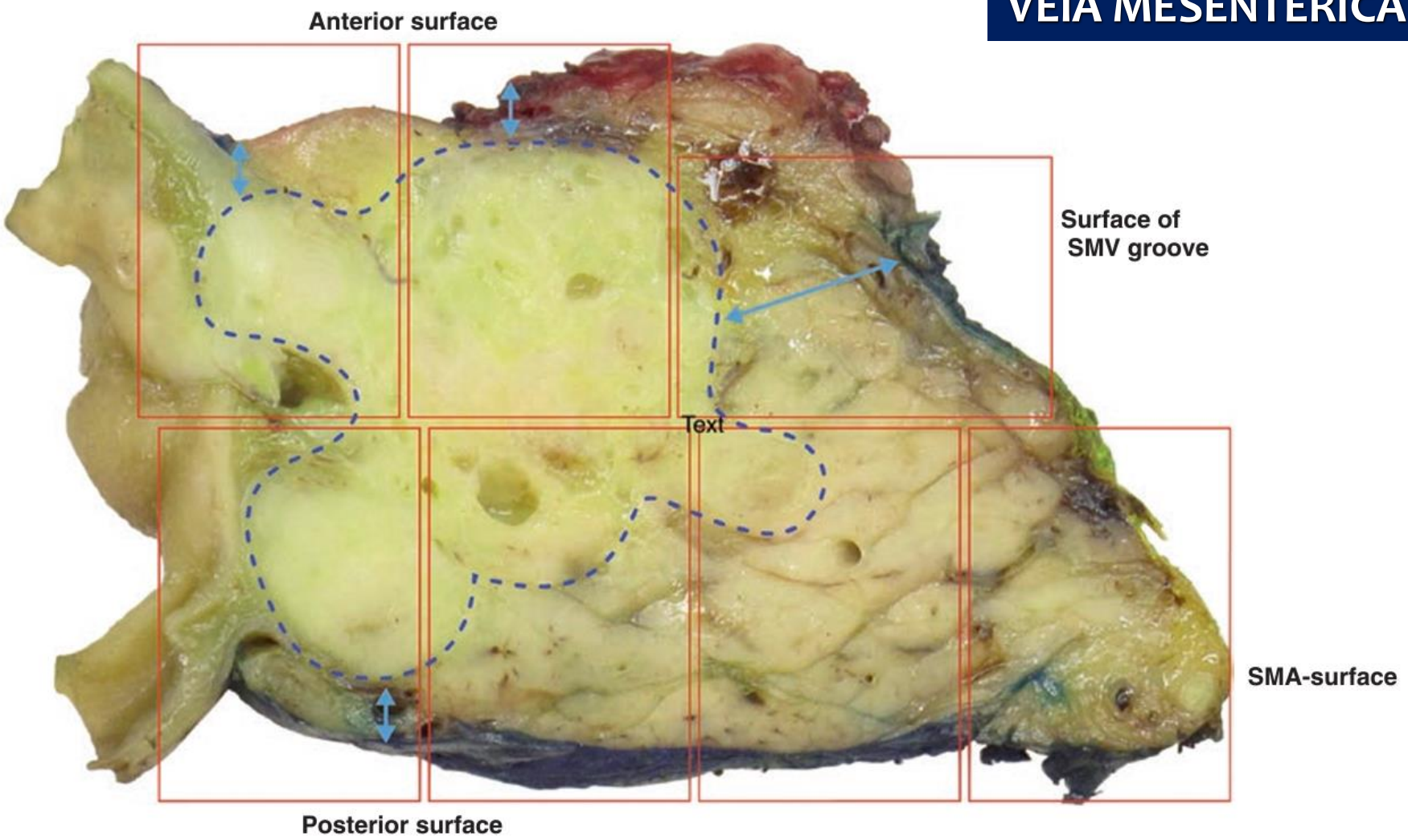




Veia mesentérica superior (SMV)
Artéria mesentérica superior (SMA)

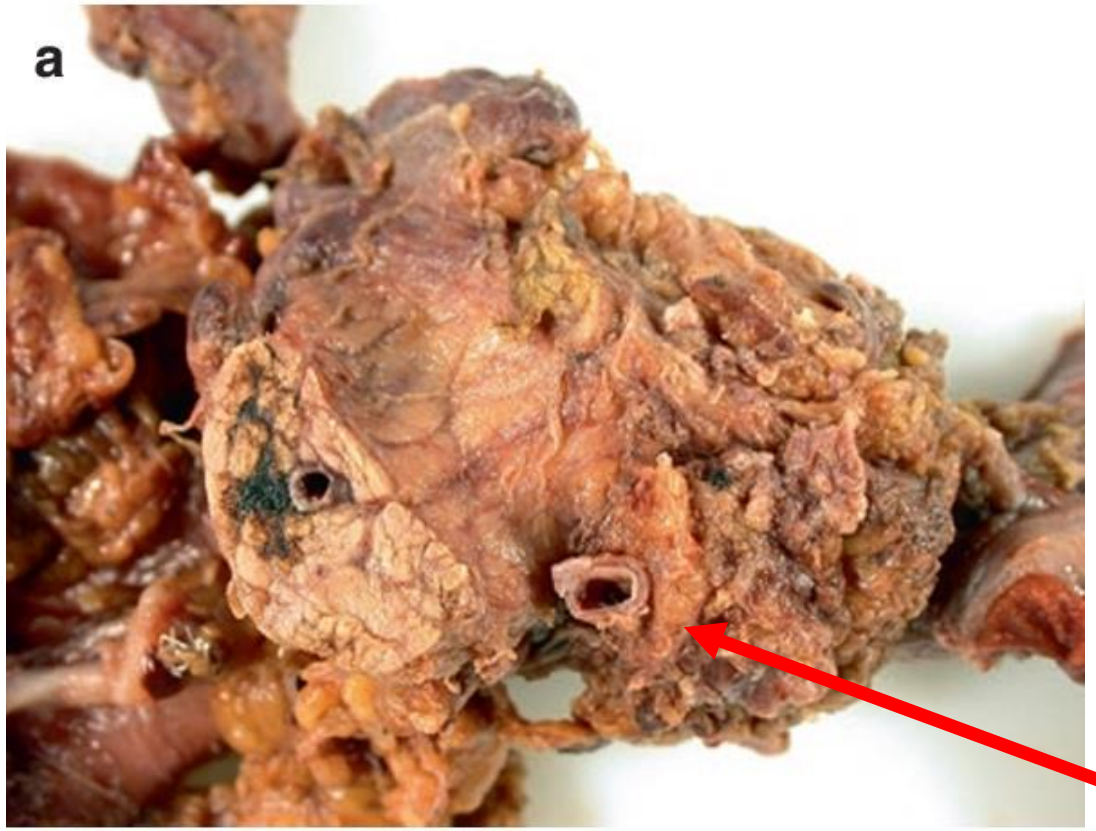
Verbeke C, et al. Cancer Treat Rev. 2015;41:17–26

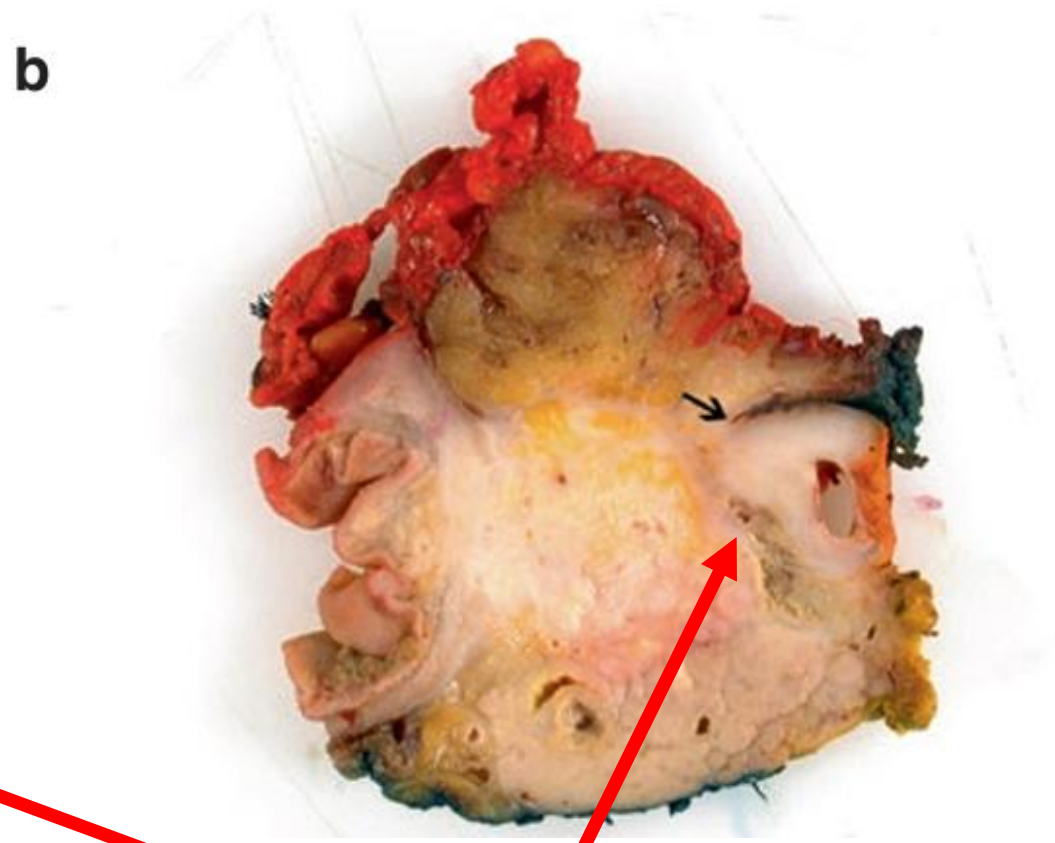
VEIA MESENTÉRICA SUPERIOR



ARTÉRIA MESENTÉRICA SUPERIOR

Campbell F and Verbeke C. Pathology of the pâncreas. Springer 2021





VEIA MESENTÉRICA SUPERIOR

Campbell F and Verbeke C. Pathology of the pâncreas. Springer 2021

JAMA Surgery | Original Investigation

Patterns of Recurrence After Resection of Pancreatic Ductal Adenocarcinoma

A Secondary Analysis of the ESPAC-4 Randomized Adjuvant Chemotherapy Trial

ESPAC-4

Table 2. Sites of First Recurrence and Median Overall Survival From Surgery and Median Survival After Diagnosis of Recurrence by Site

Site of Recurrence	No.	Median (95% CI)		
		Recurrence-Free Survival, mo	Survival After Recurrence, mo	Overall Survival, mo
Local only	238	13.57 (12.61-14.06)	9.36 (8.08-10.48)	24.83 (22.96-27.863)
Local and distant recurrence	48	11.99 (10.28-15.83)	8.11 (5.22-11.79)	23.82 (17.48-28.32)
Distant only	193	11.14 (10.05-12.32)	9.23 (7.82-11.43)	20.61 (18.12-23.80)

Total: 730
Recorrência 479 (65.6%)
Local 238 (479): 49.7%
Distante 193 40.3%
Simultânea 48: 10.0%

DOENÇA RESIDUAL

Jones RP, et al. JAMA Surg 2019

Received: 14 April 2019 | Revised: 18 May 2019 | Accepted: 6 June 2019

DOI: 10.1002/ags3.12273

REVIEW ARTICLE

AGSurg Annals of Gastroenterological Surgery Open Access WILEY

Local radicality and survival outcome of pancreatic cancer surgery

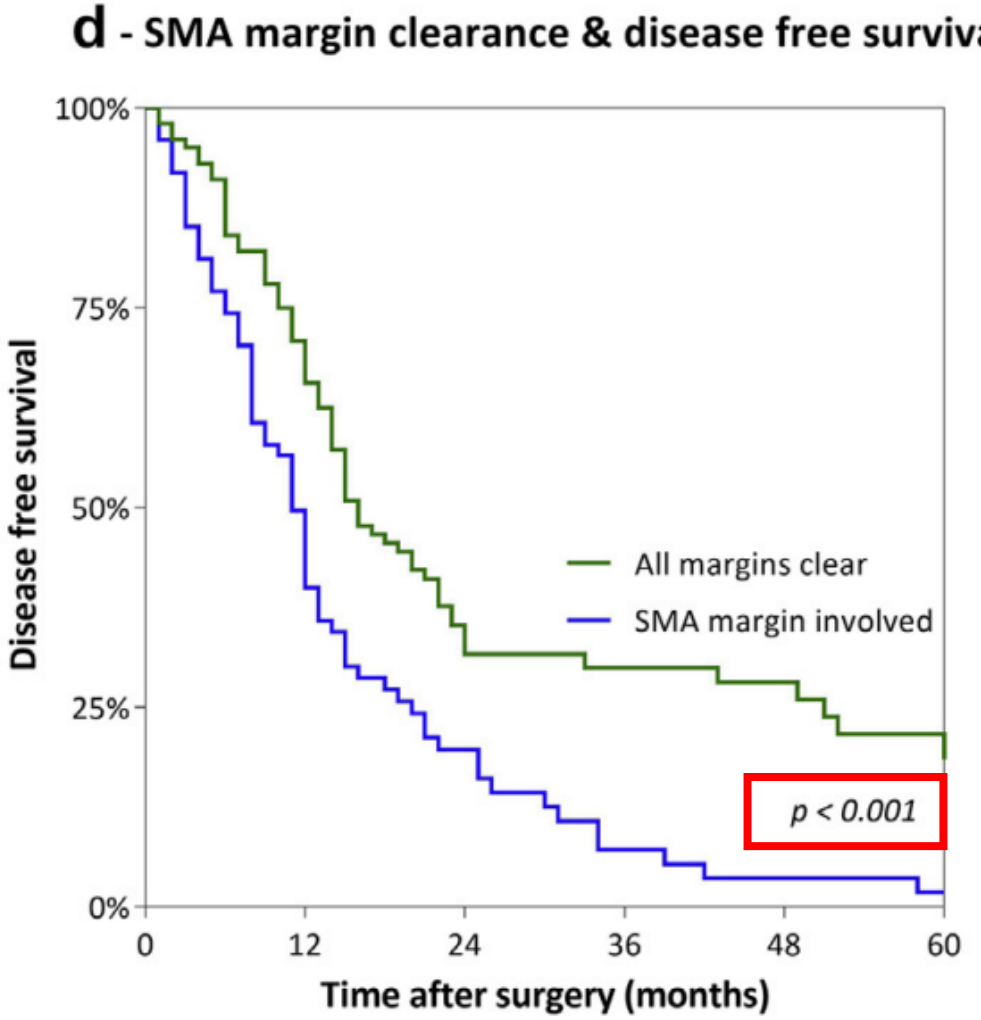
TABLE 2 The effect of positive resection margins on survival in pancreatic cancer

Study	Type of study	Patients included	Type of surgery	R-definition	R0/R1 rate, absolute (%)	Years	Median survival	5-year survival rate	Adjuvant (chemo-) therapy
Uesaka 2016[4] JASPAC 01	RCT	385	257 (68%): PD 116 (13%): DP 4 (19%): TP	0-mm rule	R0 > 0 mm: 49 (13%) R1 0 mm: 328 (87%)	2007-2010			Yes: 98.7%
		190 GEM	136 (72%): PD 50 (26%): DP 4 (2%): TP		R0 > 0 mm: 26 (14%) R1 0 mm: 164 (86%)		25.5 months	24.4%	
		187 S-1	121 (65%): PD 66 (35%): DP 0 (0%): TP		R0 > 0 mm: 23 (12%) R1 0 mm: 164 (88%)		46.5 months	44.1%	
Strobel 2017[41]	Retrospective single-center	561	561 PD 72 (12.8%): cPD 427 (76.1%): ppPD 62 (11.1%): prPD	1-mm rule	R0 > 1 mm: 112 (20%) R1 0-1 mm: 123 (21.9%) R1 0 mm: 326 (58.1%)	2006-2012	R0 > 1 mm: 41.6 months R1 0-1 mm: 27.5 months R1 0 mm: 23.4 months	37.7% 30.1% 20.3%	Yes: 438 (78.1%) No: 72 (12.8%) NA: 51 (9.1%)
Hank 2018[42]	Retrospective single-center	455	218 DP: (47.9%) 237 TP: (52.1%)	1-mm rule	R0 > 1 mm: 107 (23.5%) R1 0-1 mm: 104 (22.9%) R1 0 mm: 244 (53.6%)	2006-2014	R0 > 1 mm: 62.4 months R1 0-1 mm: 24.6 months R1 0 mm: 17.2 months	52.6% 16.8% 13%	Yes: 81.5% No: 18.5%

https://doi.org/10.1016/j.hpb.2020.01.005 HPB

ORIGINAL ARTICLE

Recurrence patterns of pancreatic cancer after pancreatoduodenectomy: systematic review and a single-centre retrospective study



Kalisvaart M, et al. HPB 2020

Journal of Gastrointestinal Surgery
https://doi.org/10.1007/s11605-020-04619-1

ORIGINAL ARTICLE

Optimal Lymphadenectomy of the Mesopancreas Based on Fluorescence Imaging During Pancreaticoduodenectomy

Ryota Matsuki[1] · Masanori Sugiyama[2] · Masaharu Kogure[1] · Masaaki Yokoyama[3] · Tetsuya Nakazato[1] · Yutaka Suzuki[1] · Toshiyuki Mori[1] · Nobutsugu Abe[1] · Yoshihiro Sakamoto[1]

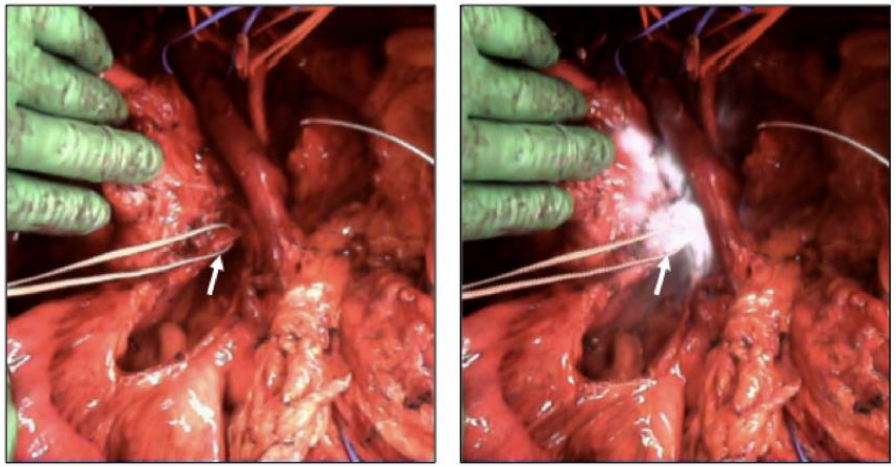


Fig. 1 Lymphatic pathways from the pancreatic head. The first JA is taped. Fluorescence is seen in the mesentery of the IPDA and first JA (arrow), but not in that of the second JA or more distant

Table 2 Lymphatic pathways around the mesopancreas in the patients injected with ICG

No	Time after injection of ICG (min)	Mesentery along the IPDA-J1A	Mesentery along the J2A	Mesentery along the middle colic artery	Along the SMA
1	112	○	×	×	○
2	117	○	×	×	○
3	145	○	×	×	○
4	217	○	×	×	○
5	170	○	×	×	○
6	246	○	×	×	○
7	157	○	×	×	○
8	175	×	×	×	○
9	280	○	×	×	○
10	180	○	×	×	○

○: Positive staining
×: Negative staining
ICG indocyanine green, *IPDA* inferior pancreatoduodenal artery, *JA* jejunal artery, *SMA* superior mesenteric artery

Matsuki R, et al. J Gastrointest 2020

PANCREATIC CANCER

World J Surg
https://doi.org/10.1007/s00268-020-05856-w

ORIGINAL SCIENTIFIC REPORT

Complete Lymphadenectomy Around the Entire Superior Mesenteric Artery Improves Survival in Artery-First Approach Pancreatoduodenectomy for T3 Pancreatic Ductal Adenocarcinoma

http://dx.doi.org/10.1016/j.hpb.2015.11.009 HPB

REVIEW ARTICLE

A systematic review of the role of periadventitial dissection of the superior mesenteric artery in affecting margin status after pancreatoduodenectomy for pancreatic adenocarcinoma

Journal of Surgical Oncology 2016;113:668–671

HOW I DO IT

Top-Down Approach to the Superior Mesenteric Artery and the Mesopancreas During Pancreatoduodenectomy for Pancreatic Cancer

THILO WELSCH, MD,* ULRICH BORK, MD, MARIUS DISTLER, MD, AND JÜRGEN WEITZ, MD

www.impactjournals.com/oncotarget/ Oncotarget, 2017, Vol. 8, (No. 5), pp: 7766-7776

Research Paper

Superior mesenteric artery margin in pancreaticoduodenectomy for pancreatic adenocarcinoma

Dao-ning Liu[1], Ang Lv[1], Zhi-hua Tian[2], Xiu-yun Tian[1], Xiao-ya Guan[1], Bin Dong[2], Min Zhao[3], Chun-yi Hao[1]

DOI: 10.1002/jhbp.725

ORIGINAL ARTICLE

Precise anatomical resection based on structures of nerve and fibrous tissue around the superior mesenteric artery for mesopancreas dissection in pancreaticoduodenectomy for pancreatic cancer

Yuichi Nagakawa[1] | Shuang-Qin Yi[2] | Chie Takishita[1] | Yatsuka Sahara[1] |

Surgical Endoscopy
https://doi.org/10.1007/s00464-019-06994-6

DYNAMIC MANUSCRIPT

Follow "the superior mesenteric artery": laparoscopic approach for total mesopancreas excision during pancreaticoduodenectomy

Edouardo Morales[1] · Giuseppe Zimmitti[1] · Claudio Codignola[1] · Alberto Manzoni[1] · Marco Garatti[1] · Valentina Sega[1] · Edoardo Rosso[1]

Anatomical Science International
https://doi.org/10.1007/s12565-020-00597-1

ORIGINAL ARTICLE

What comprises the plate-like structure between the pancreatic head and the celiac trunk and superior mesenteric artery? A proposal for the term "P–A ligament" based on anatomical findings

Satoru Muro[1] · Wachirawit Sirirat[1] · Daisuke Ban[2] · Yuichi Nagakawa[3] · Keiichi Akita[1]

J Gastrointest Surg (2014) 18:1209–1215
DOI 10.1007/s11605-014-2495-3

HOW I DO IT

Anterior Approach to the Superior Mesenteric Artery by Using Nerve Plexus Hanging Maneuver for Borderline Resectable Pancreatic Head Carcinoma

Shugo Mizuno · Shuji Isaji · Akihiro Tanemura · Masashi Kishiwada ·

Journal of Gastrointestinal Surgery
https://doi.org/10.1007/s11605-018-3995-3

ORIGINAL ARTICLE

Optimal Extent of Superior Mesenteric Artery Dissection during Pancreaticoduodenectomy for Pancreatic Cancer: Balancing Surgical and Oncological Safety

Yosuke Inoue[1] · Akio Saiura[1] · Atsushi Oba[1] · Shoji Kawakatsu[1] · Yoshihiro Ono[1] · Takafumi Sato[1] · Yoshihiro Mise[1] ·

—Report on Experiments and Clinical Cases—

Left Posterior Approach Pancreaticoduodenectomy with Total Mesopancreas Excision and Circumferential Lymphadenectomy Around the Superior Mesenteric Artery for Pancreatic Head Carcinoma

Takayuki Aimoto[1], Satoshi Mizutani[2], Youichi Kawano[1], Akira Matsushita[1], Naoyuki Yamashita[2], Hideyuki Suzuki[2] and Eiji Uchida[1]

International Journal of Surgery 73 (2020) 14–24

Contents lists available at ScienceDirect

International Journal of Surgery

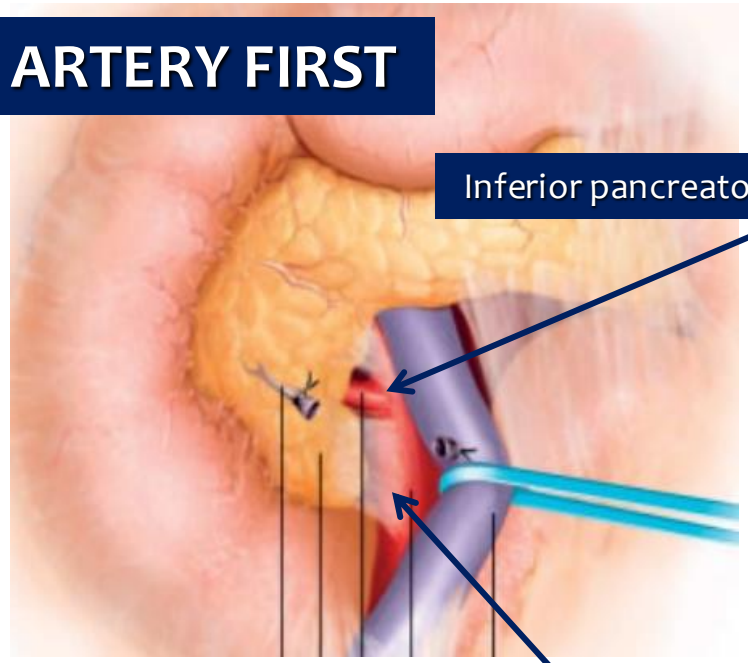
journal homepage: www.elsevier.com/locate/ijsu

Review

Superior mesenteric artery first approach can improve the clinical outcomes of pancreaticoduodenectomy: A meta-analysis

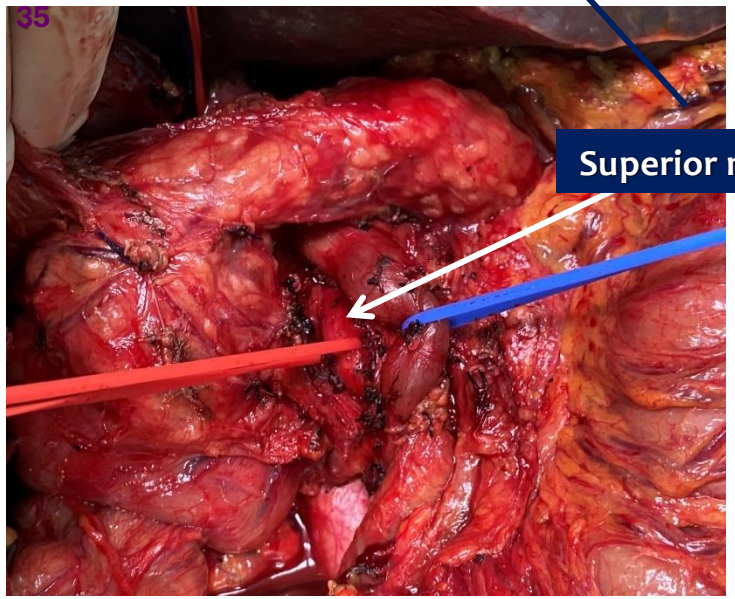
SUPERIOR MESENTERIC ARTERY

ARTERY FIRST

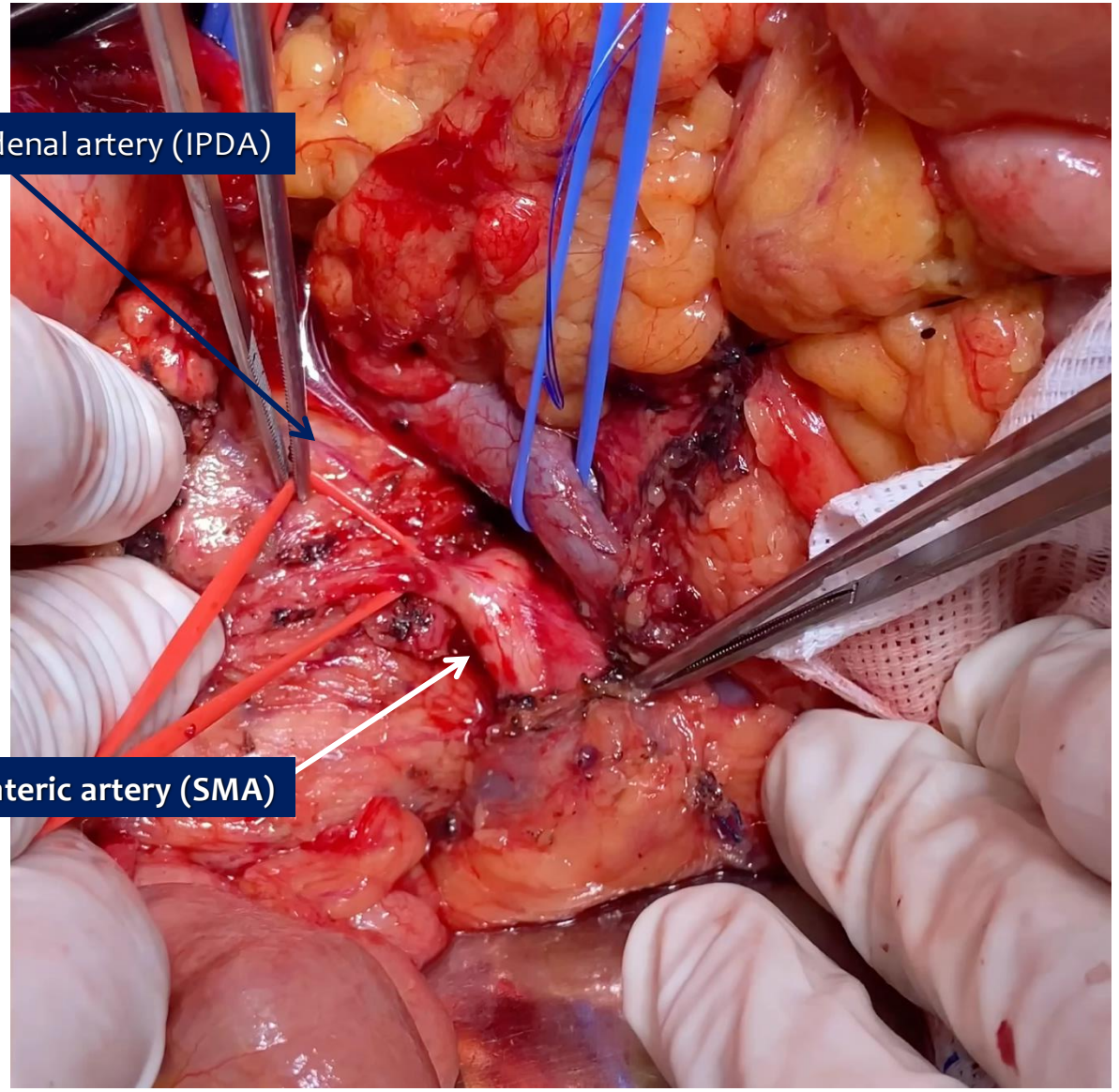


Inferior pancreatoduodenal artery (IPDA)

Pandanaboyana S, et al. Br J Surg 2012;99:1027–35



Superior mesenteric artery (SMA)



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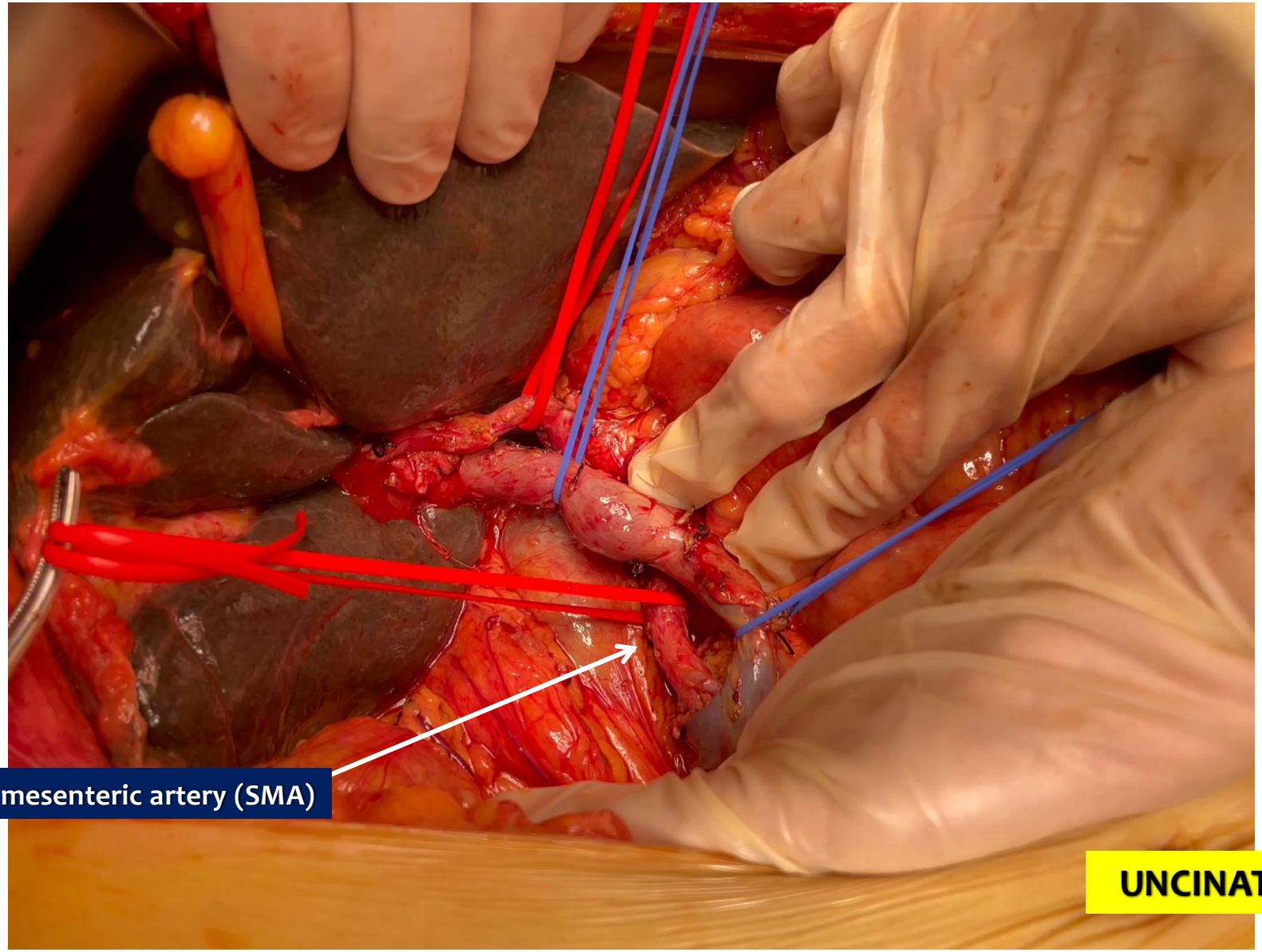

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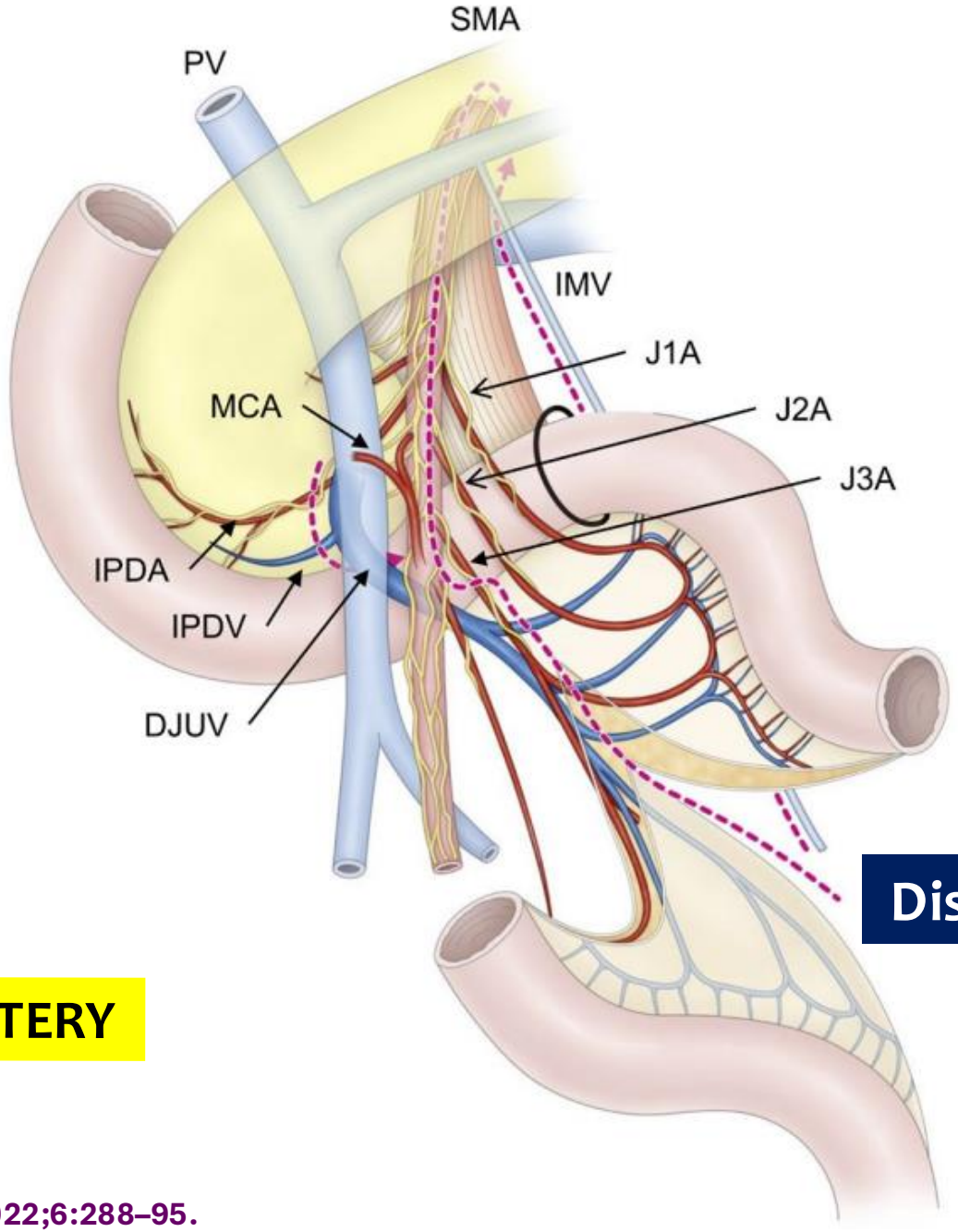
MESOPANCREAS

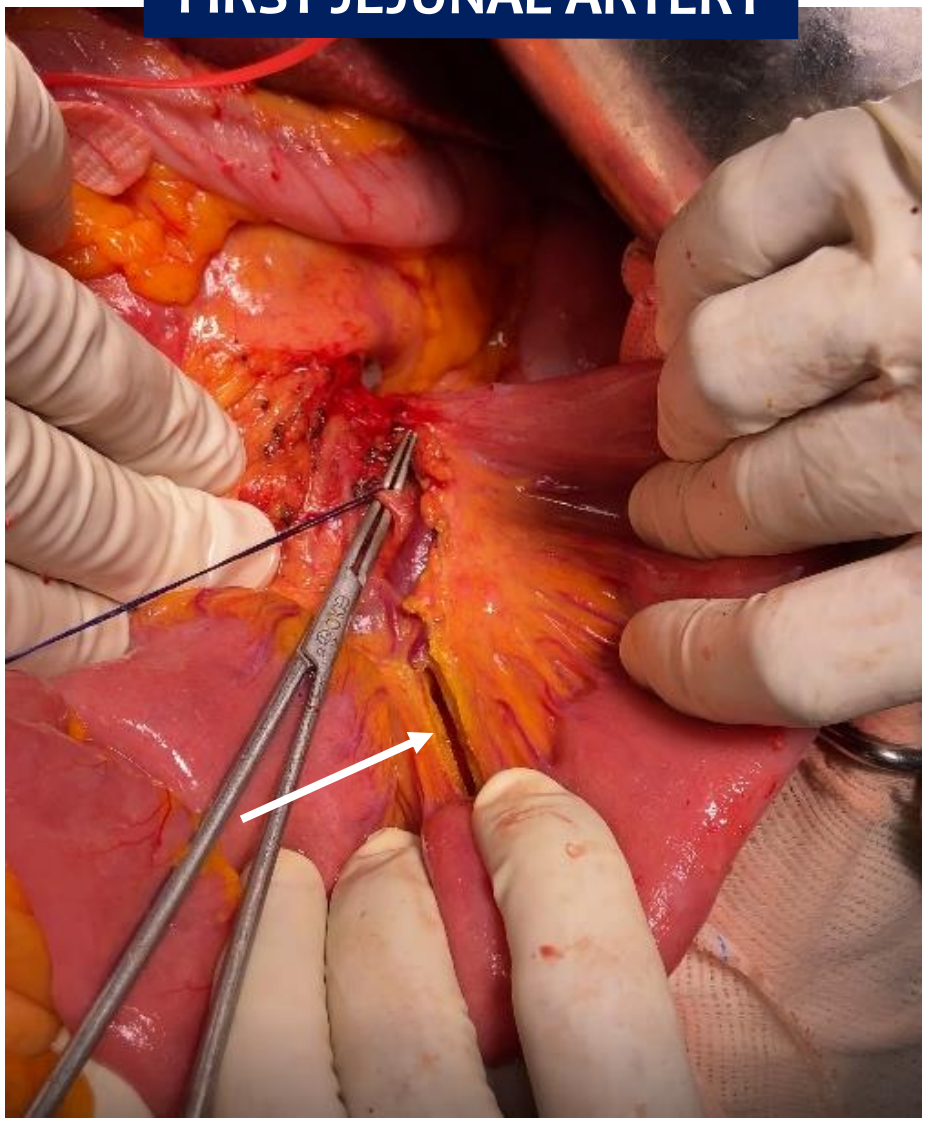


Dissecting line

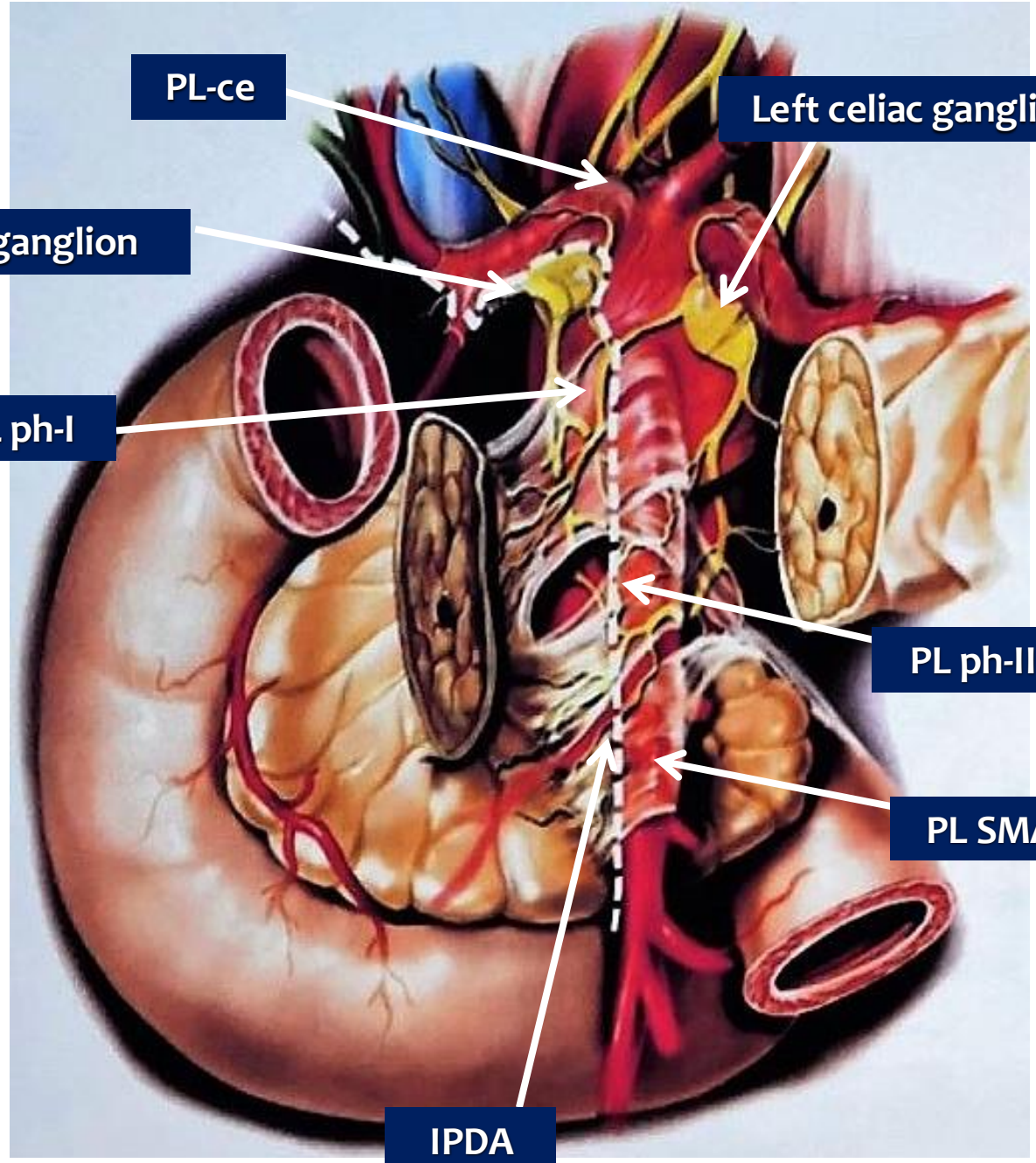
FIRST JEJUNAL ARTERY

Honjo M, et al. Ann Gastroenterol Surg. 2022;6:288–95.

FIRST JEJUNAL ARTERY



TOTAL MESOPANCREAS EXCISION

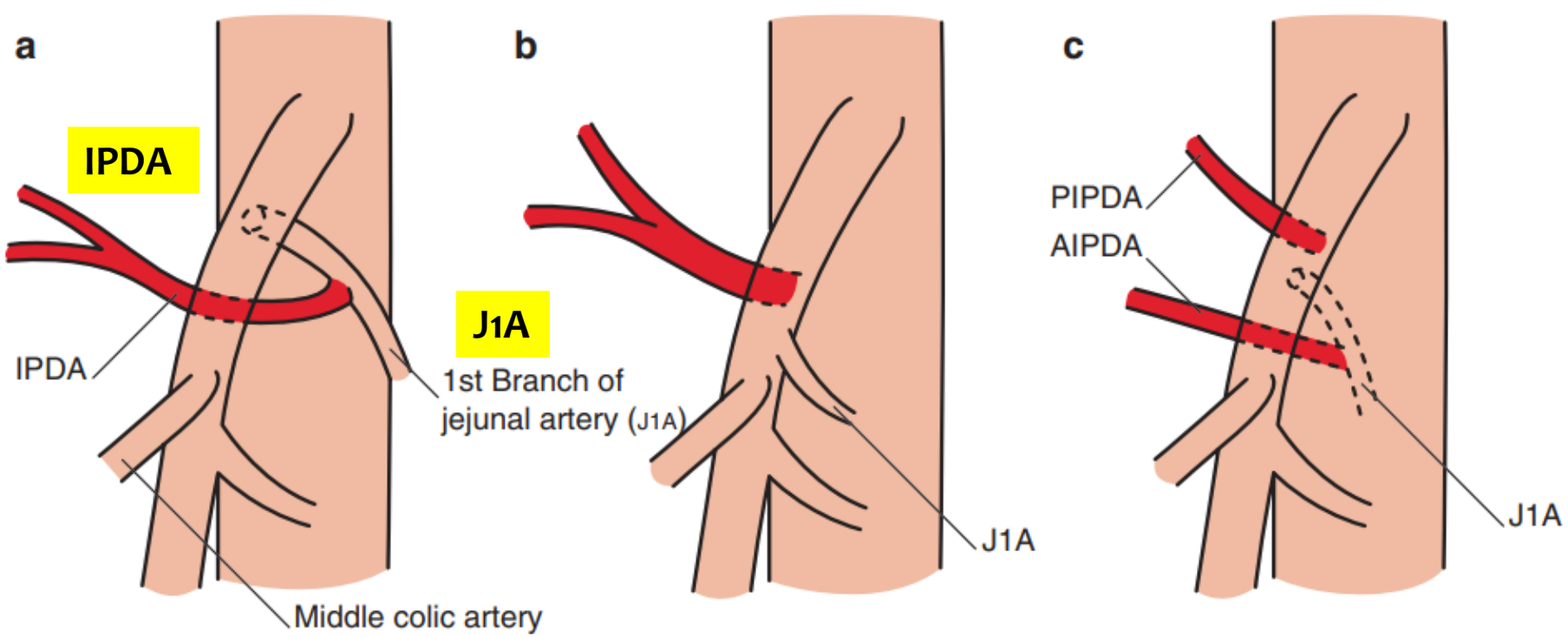


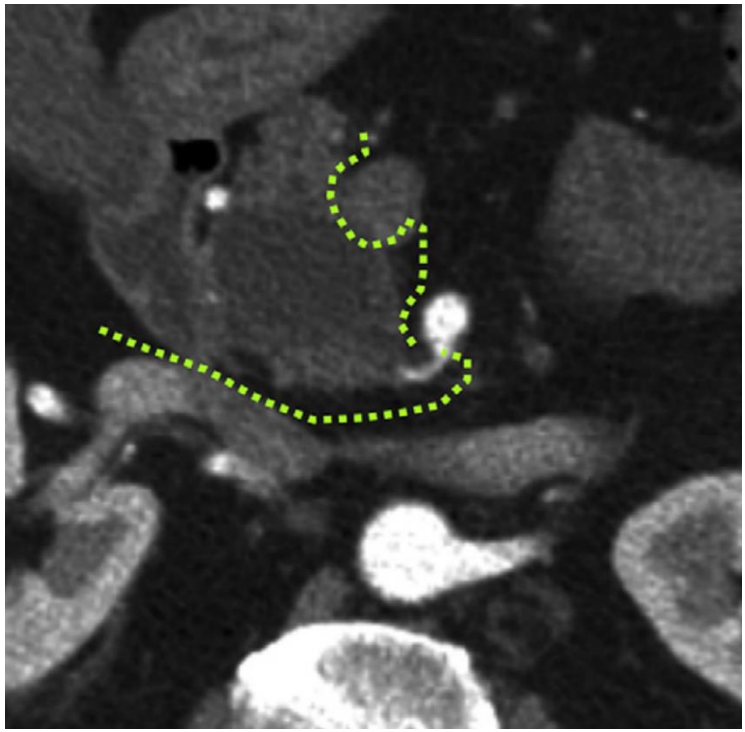
MESOPANCREAS

- ❑ plPh-I
- ❑ plPh-II
- ❑ IPDA
- ❑ Jejunal arteries
- ❑ Jejunal veins
- ❑ Lymph nodes

ARTERIES

INFERIOR PANCREATODUODENAL ARTERY (IPDA)

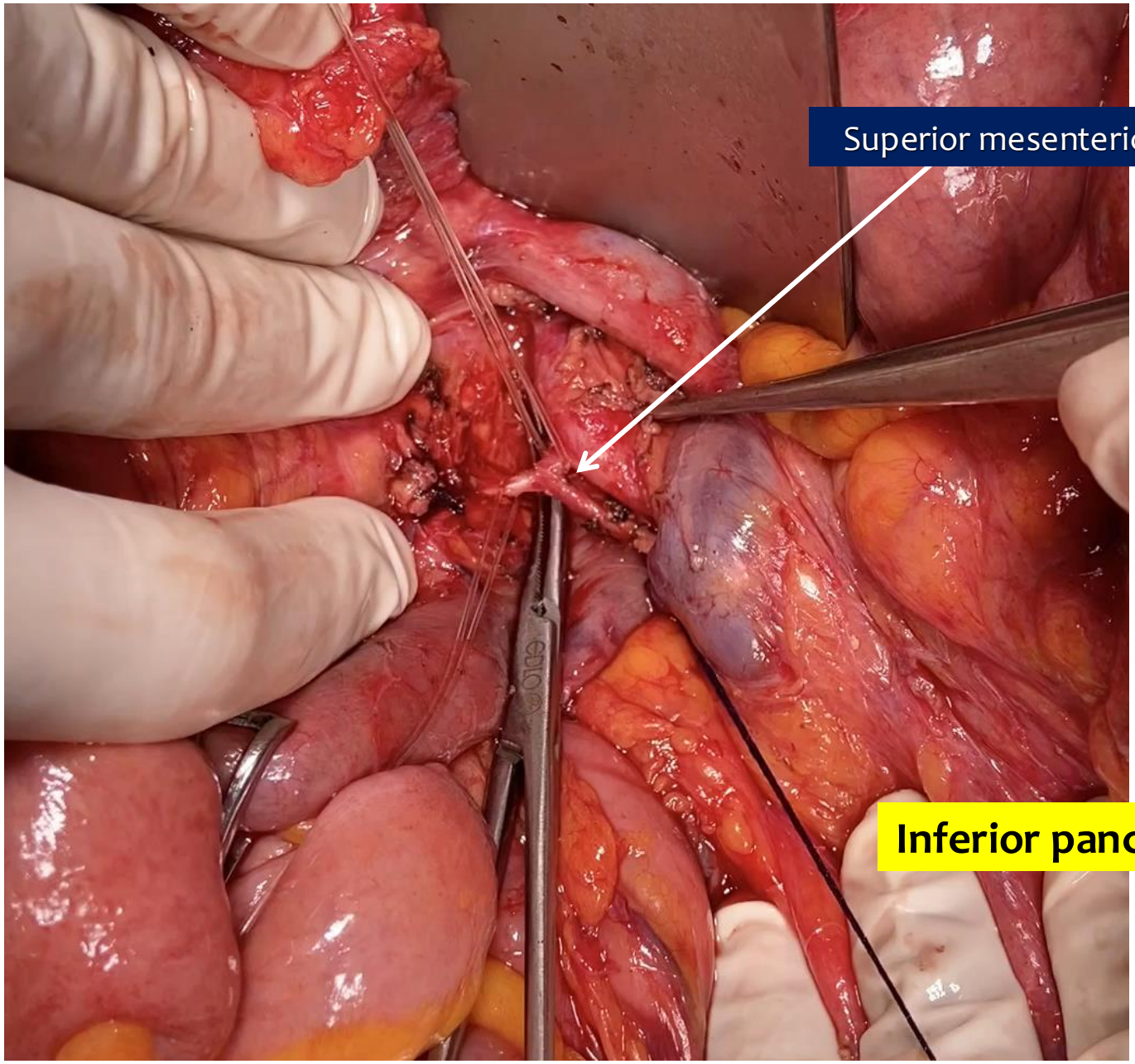




Common trunk

EPICENTRO DA DUODENOPANCREATECTOMIA

IPDA



UNCINATE FIRST

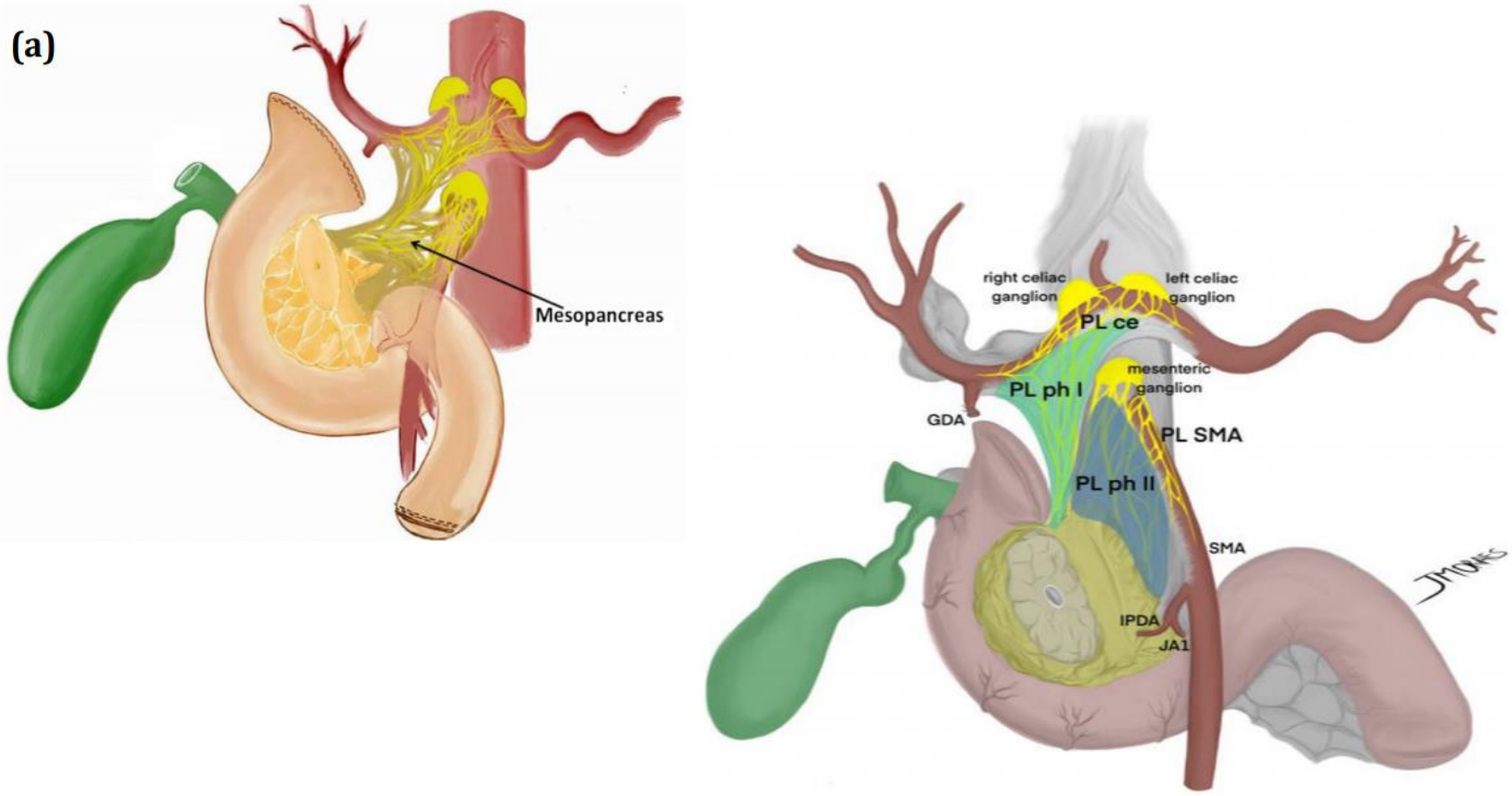
Inferior pancreatoduodenal artery

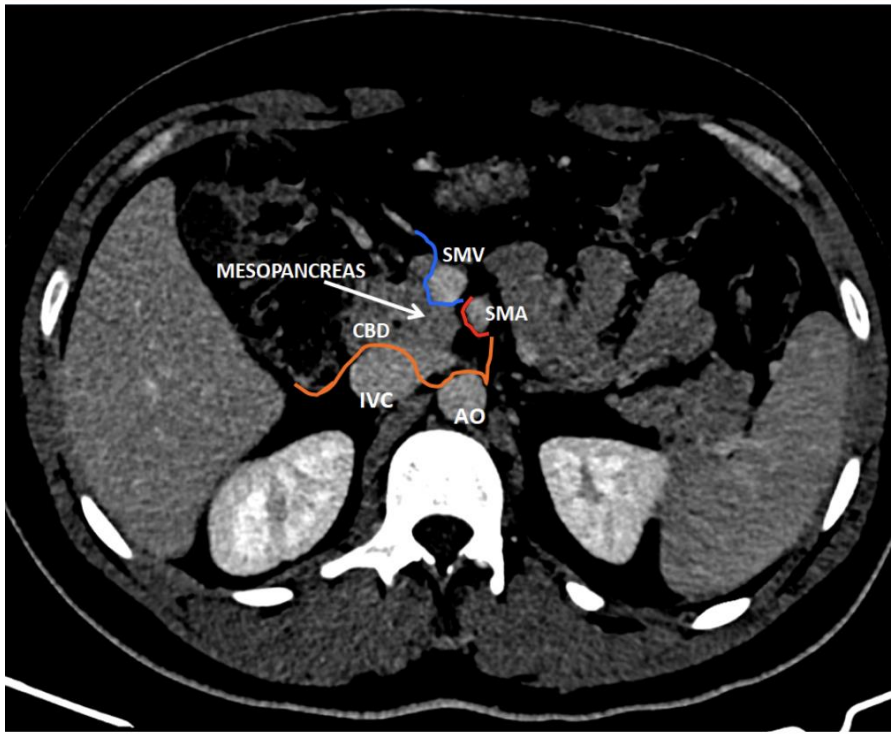
Langenbeck's Archives of Surgery
https://doi.org/10.1007/s00423-021-02211-y

REVIEW ARTICLE

What do surgeons need to know about the mesopancreas

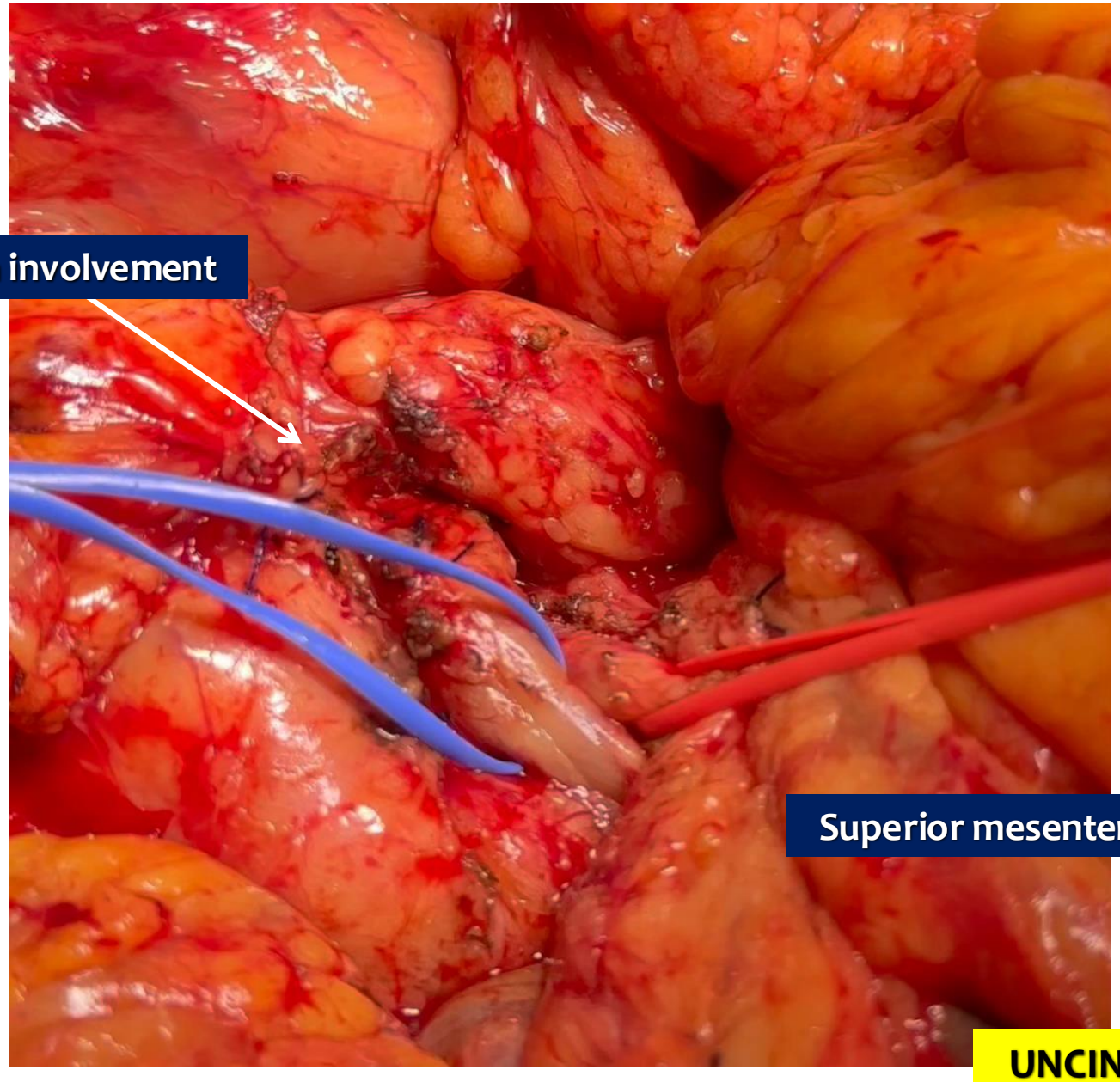
Eduardo de Souza M. Fernandes [1,2] · Oliver Strobel [3,4] · Camila Girão [1,2] · Jose Maria A. Moraes-Junior [5,6] · Orlando Jorge M. Torres [5,6]





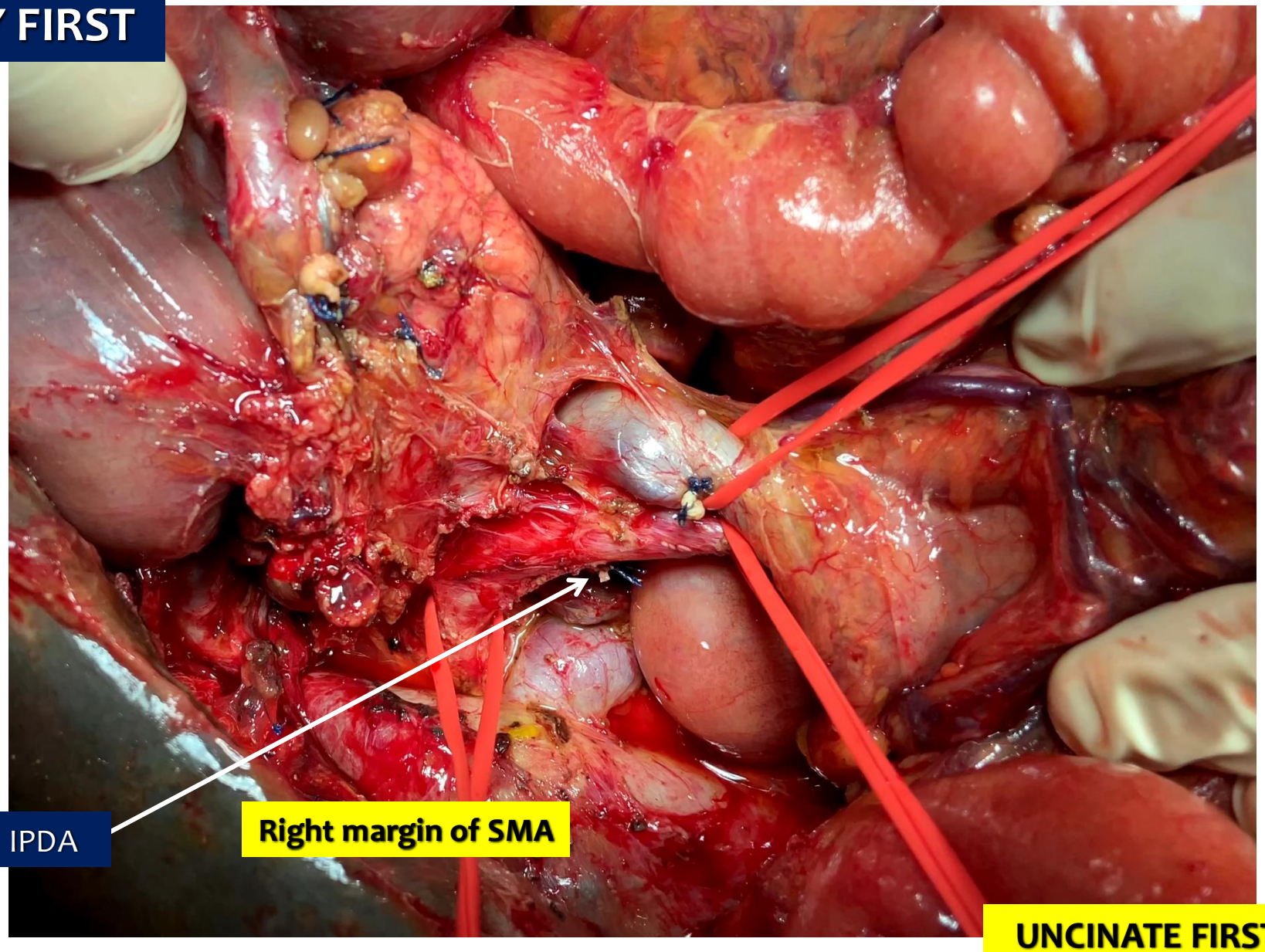
PANCREATIC HEAD PLEXUS (plPH)

Fernandes ESM, et al. Langenbeck's Arch Surg 2021



UNCINATE FIRST

ARTERY FIRST



ADVANTAGES OF ARTERY FIRST APPROACH

Table 3 Advantages of the artery-first approach (SHARMA) [35]

1. Resection without breaching the tumor extension plane, thereby minimizing cell spillage
2. Increases curative (R0) resection, decreases local recurrence
3. Complete resection of peripancreatic retroperitoneal tissue around the plexuses
4. Increased lymph nodal clearance
5. Early assessment of non-resectability (SMA involvement), avoiding useless R2 resections
6. Better delineation of SMA and identification of RHA anomalies
7. Easier en bloc resection and reconstruction of SMV-PV by "no touch" technique
8. Reduced need for graft substitutions
9. Reduced operative time and blood loss (early ligation of IPDA/JA1)

ARTERY FIRST

Fernandes ESM, et al. Langenbeck's Arch Surg 2021

ARTERY FIRST

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Review

Superior mesenteric artery first approach can improve the clinical outcomes of pancreaticoduodenectomy: A meta-analysis

- Higher R0 resection rate (p< 0.001)
- Lower local recurrence rate (p< 0.0001)
- Higher overall survival:
  - 1-year p=0.015
  - 2-year p=0.005
  - 3-year p=0.001

Meta-analysis - 18 studies

Jiang X, et al. Int J Surg 2020;73:14-24

ARTERY FIRST

.1007/s00268-020-05856-w

World Journal of Surgery

ORIGINAL SCIENTIFIC REPORT

Complete Lymphadenectomy Around the Entire Superior Mesenteric Artery Improves Survival in Artery-First Approach Pancreatoduodenectomy for T3 Pancreatic Ductal Adenocarcinoma

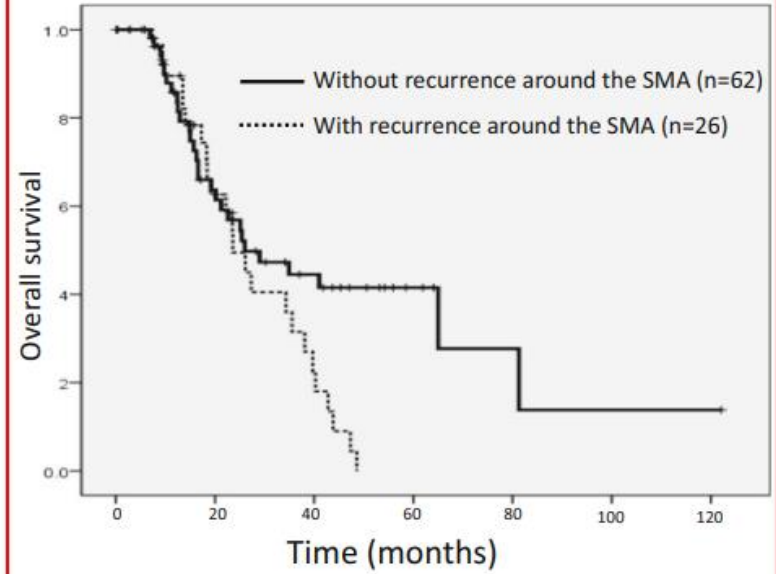

Fig. 1 Overall survival according to recurrence around the SMA. The median survival was 23.6 months in patients with recurrence around the SMA and 26 months in patients without recurrence around the SMA (p = 0.0367) SMA: superior mesenteric artery

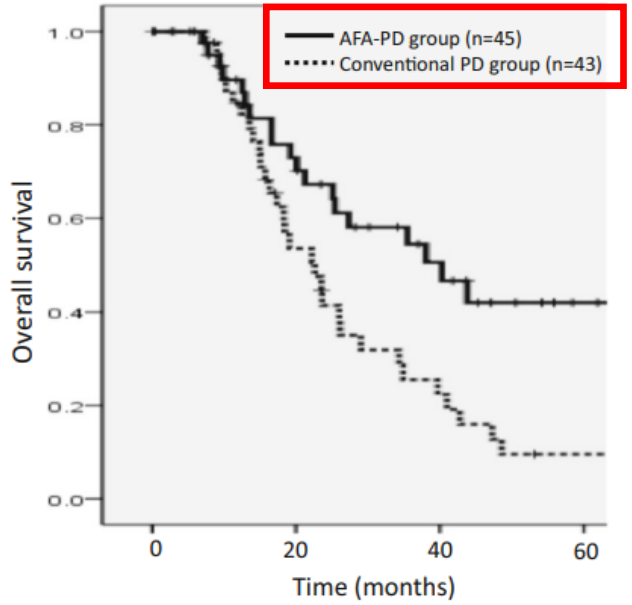

Fig. 2 Overall survival according to the type of the surgery. The median survival was 40.3 months in the AFA-PD group and 22.6 months in the conventional PD group (p = 0.005) AFA-PD: artery-first approach pancreatoduodenectomy

40.3 months vs 22.6 months (p= 0.005)

OVERALL SURVIVAL

Kobayashi S, et al. World J Surg 2020

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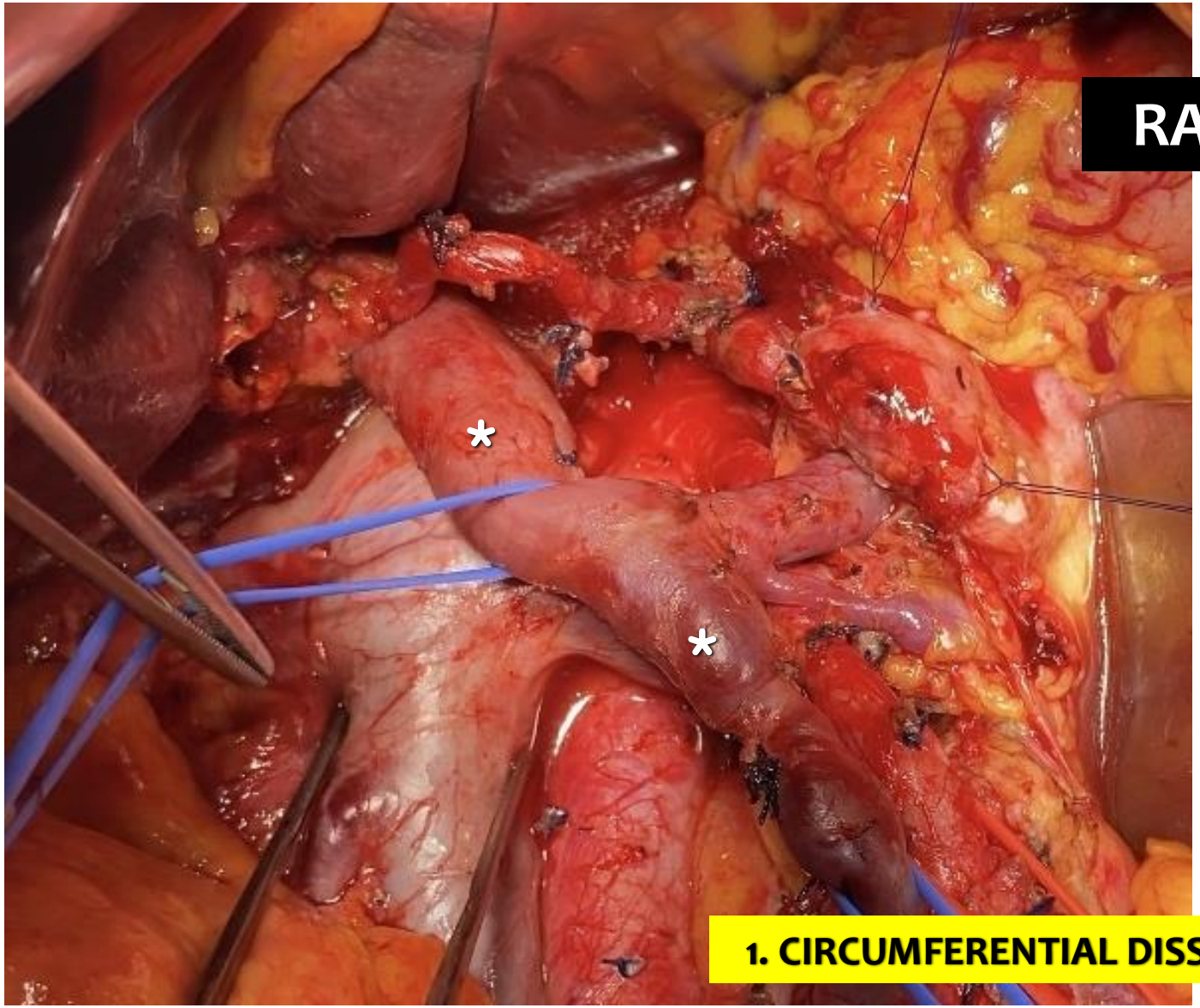
PANCREATIC HEAD PLEXUS (PL ph)

ARTERY FIRST

Fernandes ESM, et al. Langenbeck's Arch Surg 2021

TOTAL MESOPANCREAS EXCISION

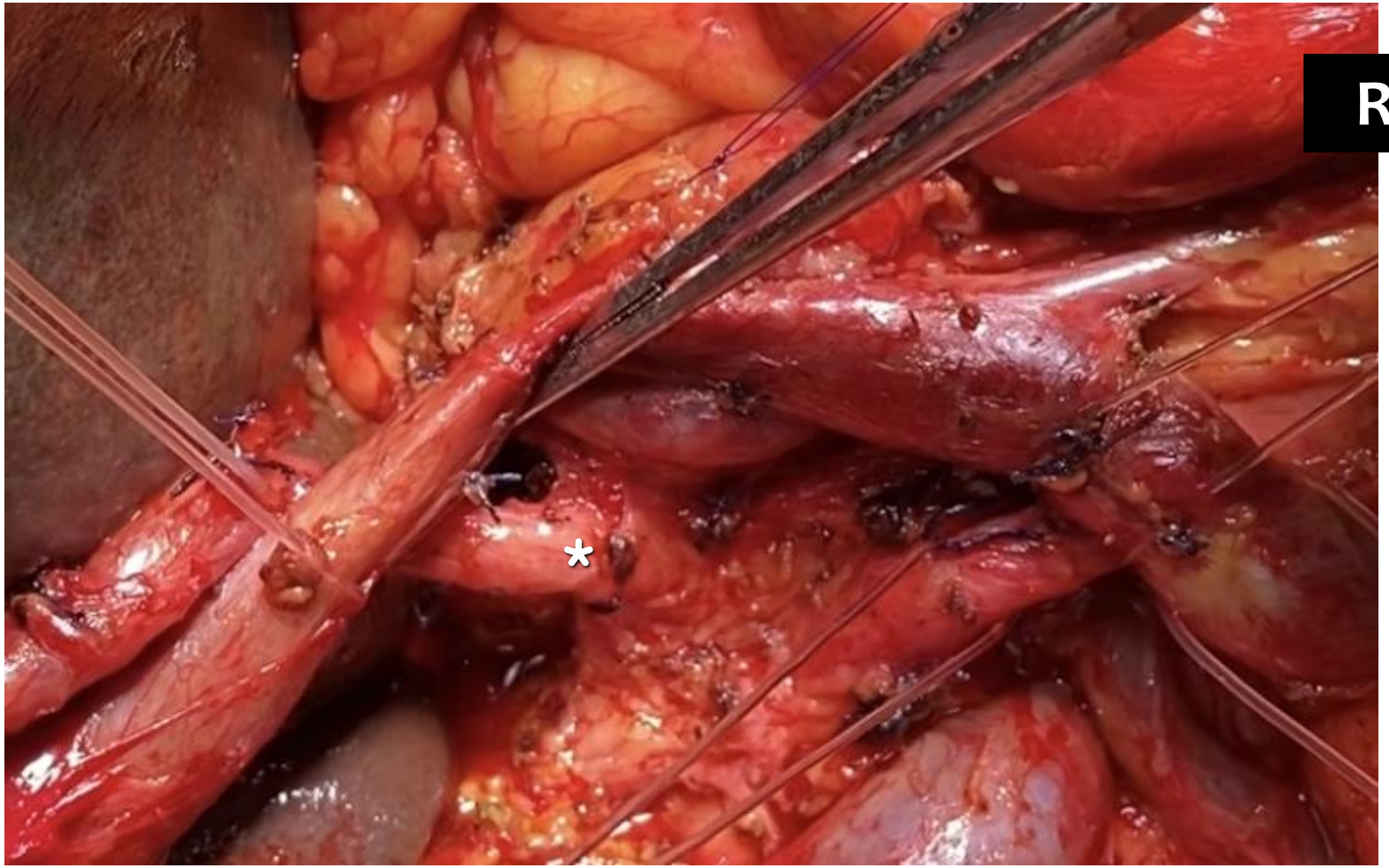


RACIONAL

1. CIRCUMFERENTIAL DISSECTION OF SMV/PV

TOTAL MESOPANCREAS EXCISION

❑Common hepatic artery lymph nodes 8a, 8p

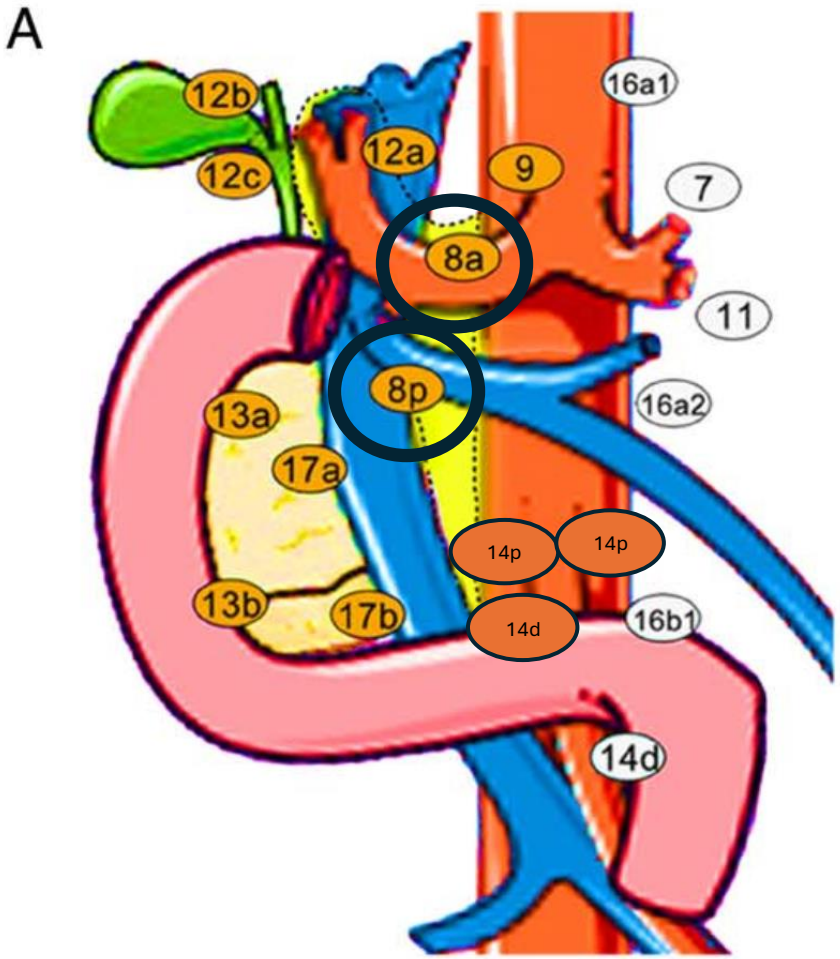


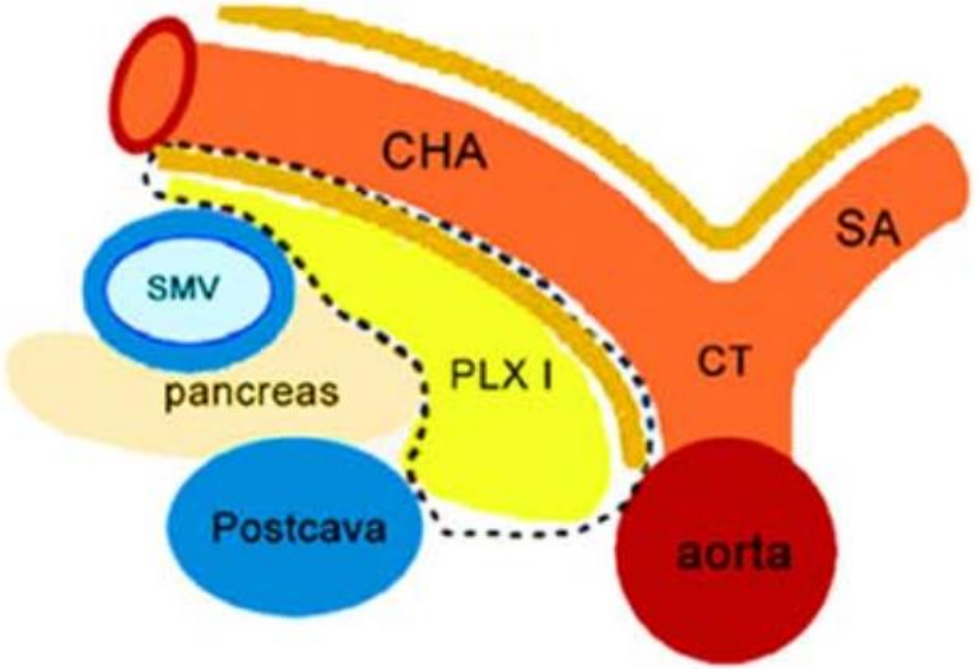
RACIONAL

2. HEMICIRCUMFERENTIAL DISSECTION OF CHA

COMMON HEPATIC ARTERY LYMPH NODES

❑8a ❑8p

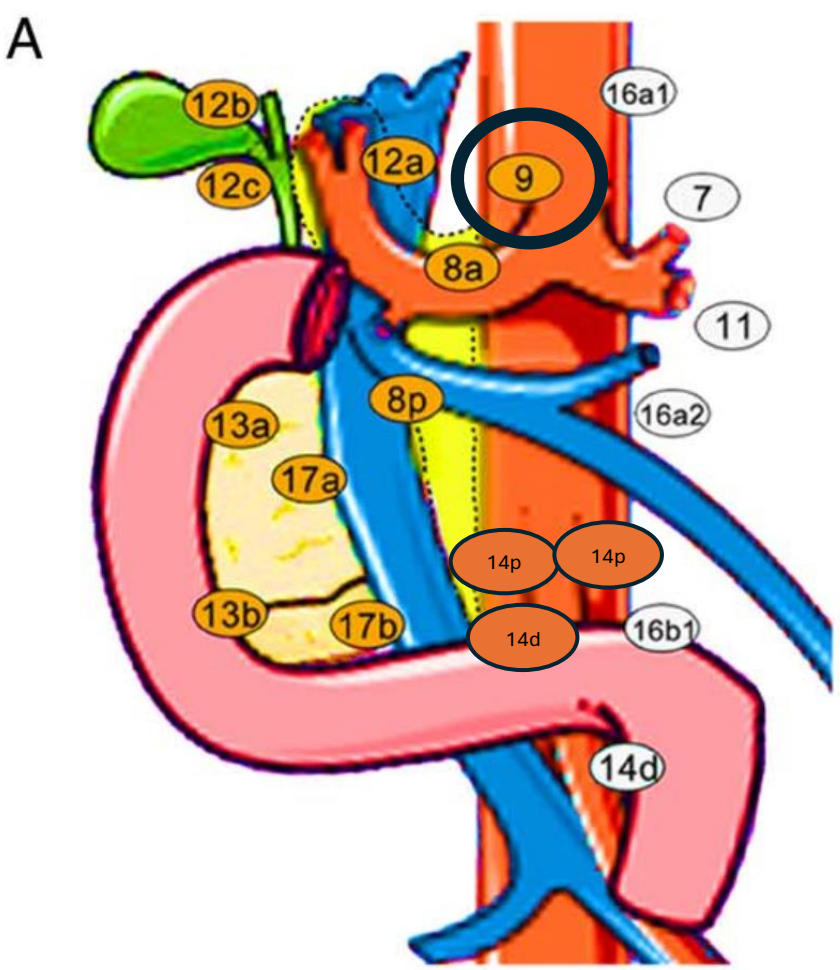




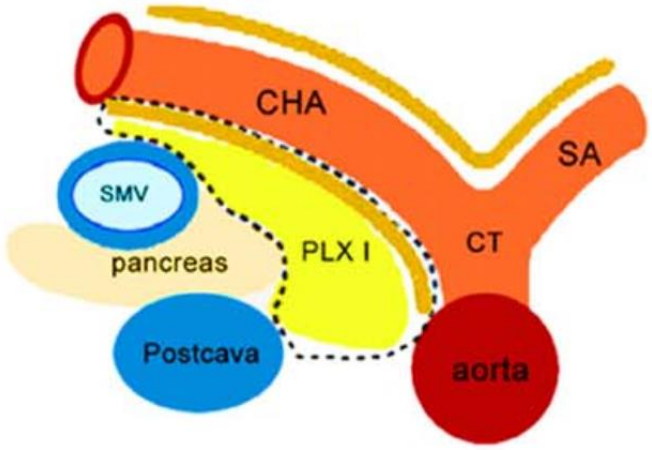
Guo X, et al. Int J Surg 2023.

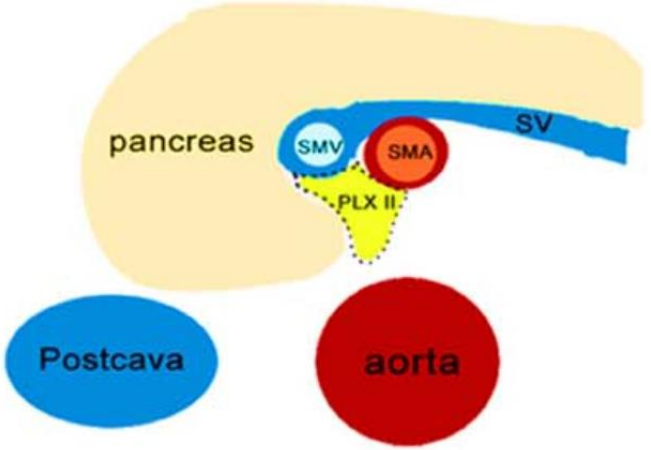
CELIAC TRUNK LYMPH NODES

❑ Celiac trunk lymph nodes 9



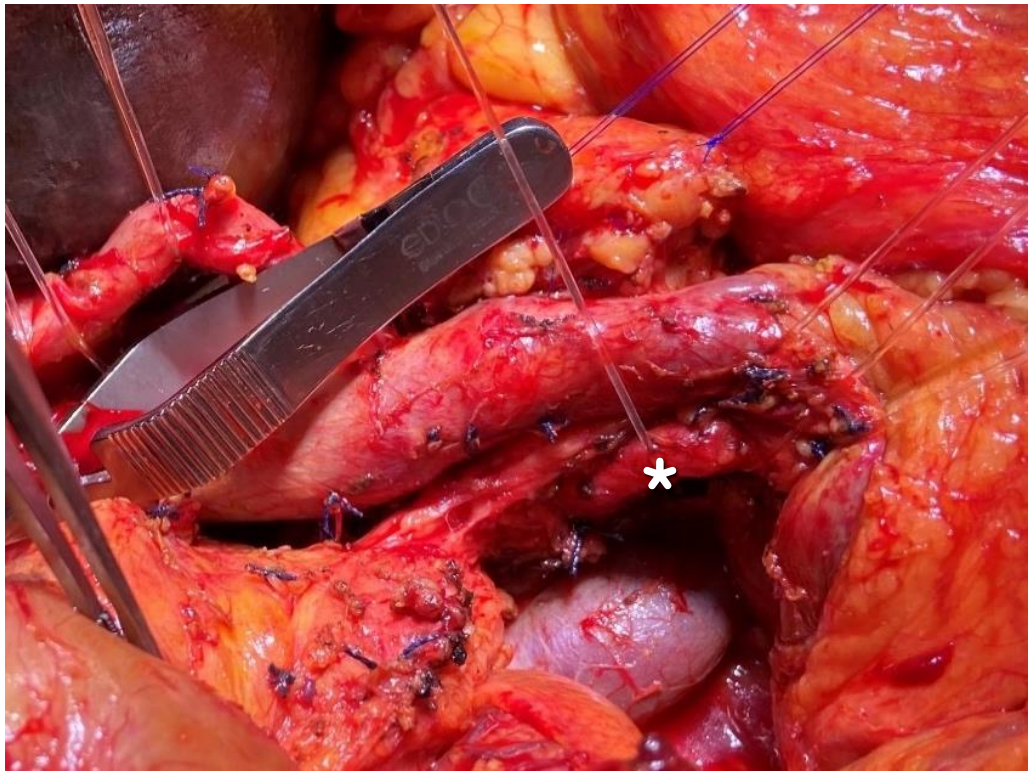
❑9



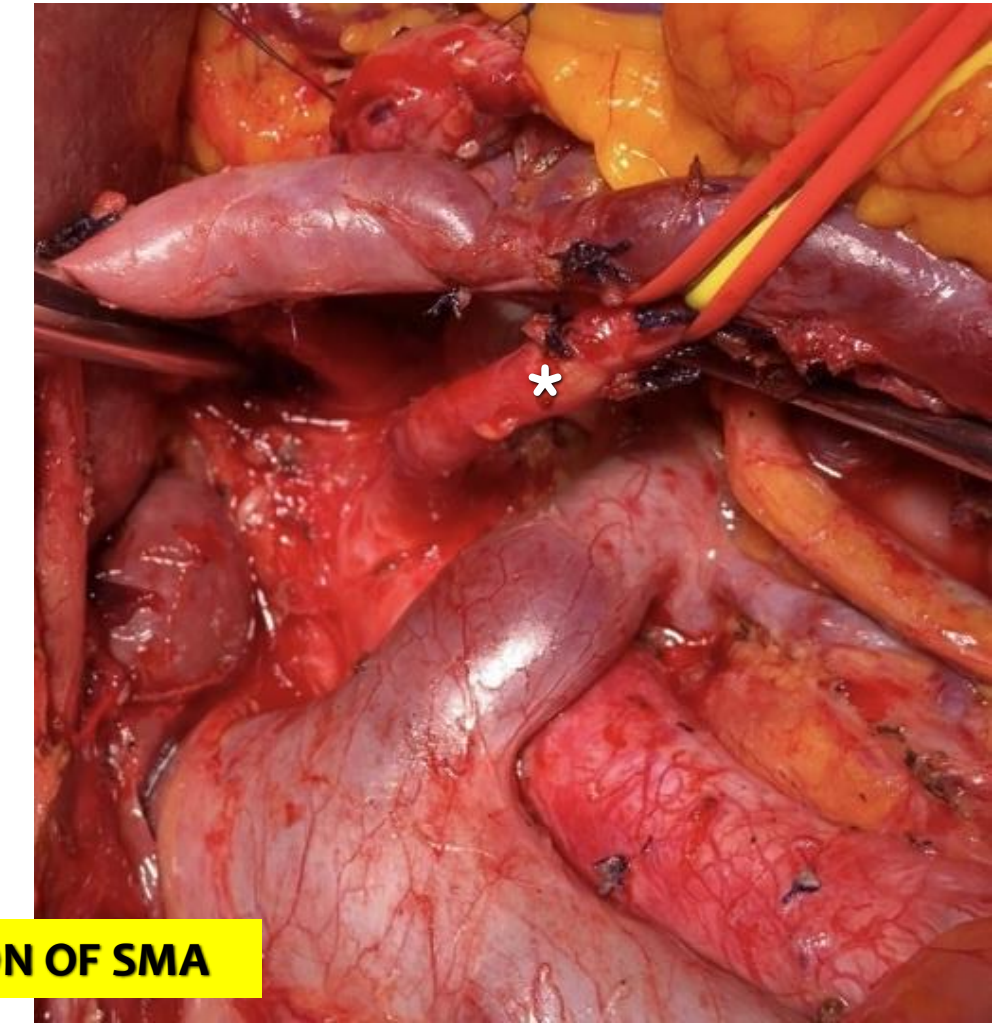


Guo X, et al. Int J Surg 2023.

TOTAL MESOPANCREAS EXCISION



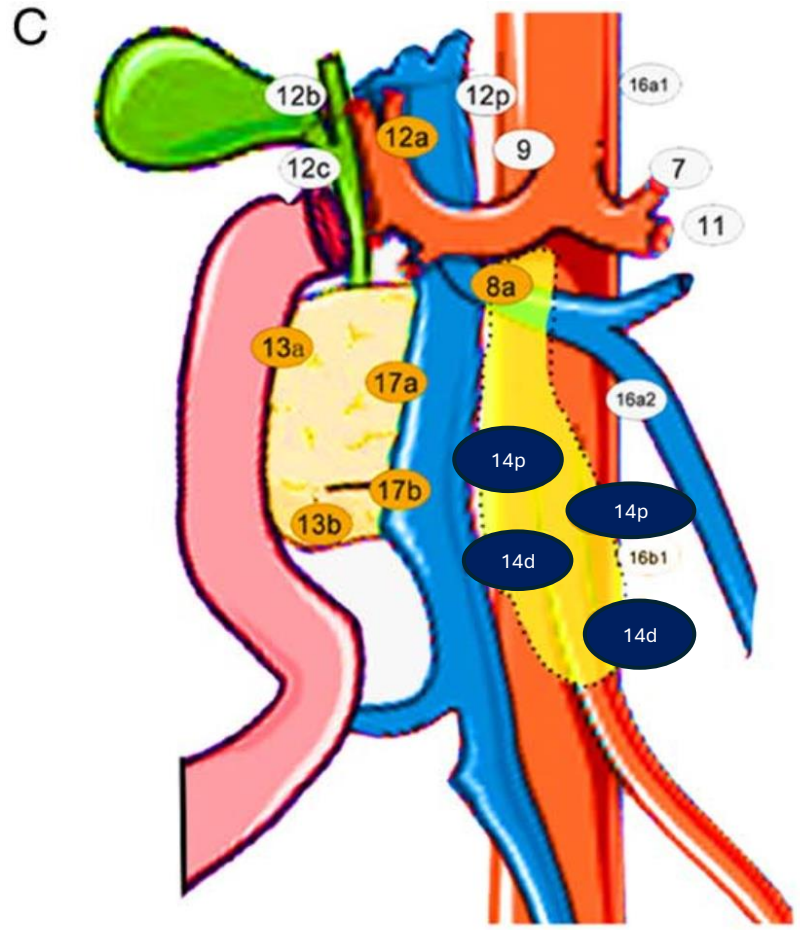
RACIONAL

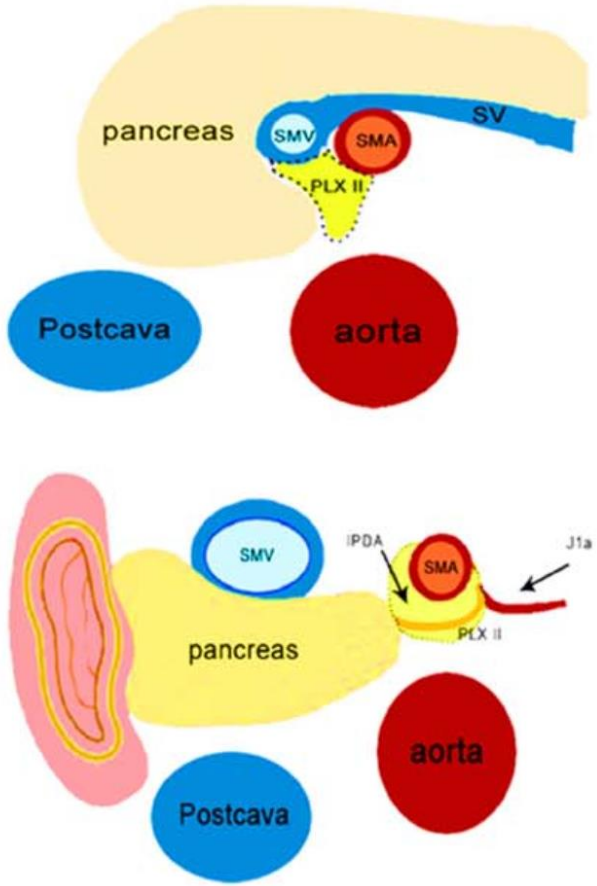


3. HEMICIRCUMFERENTIAL DISSECTION OF SMA

SUPERIOR MESENTERIC ARTERY LYMPH NODES

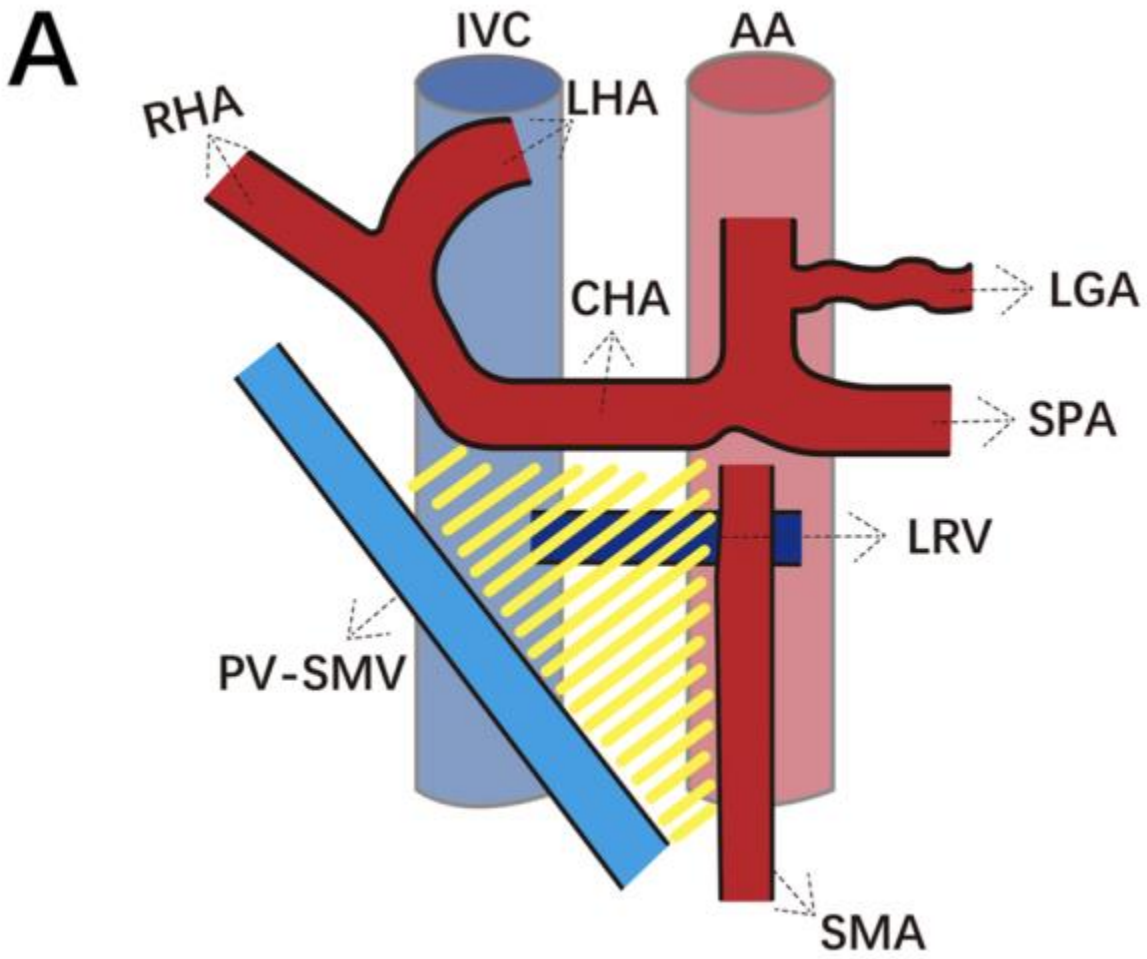
❑14p ❑14d

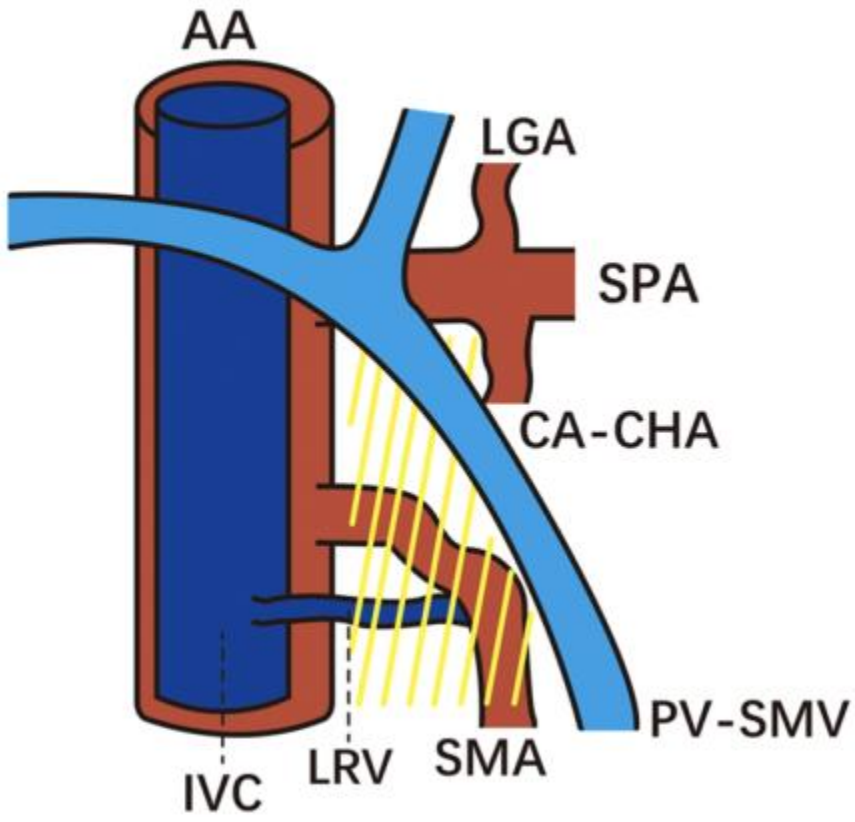




Guo X, et al. Int J Surg 2023.

TRIANGLE OPERATION



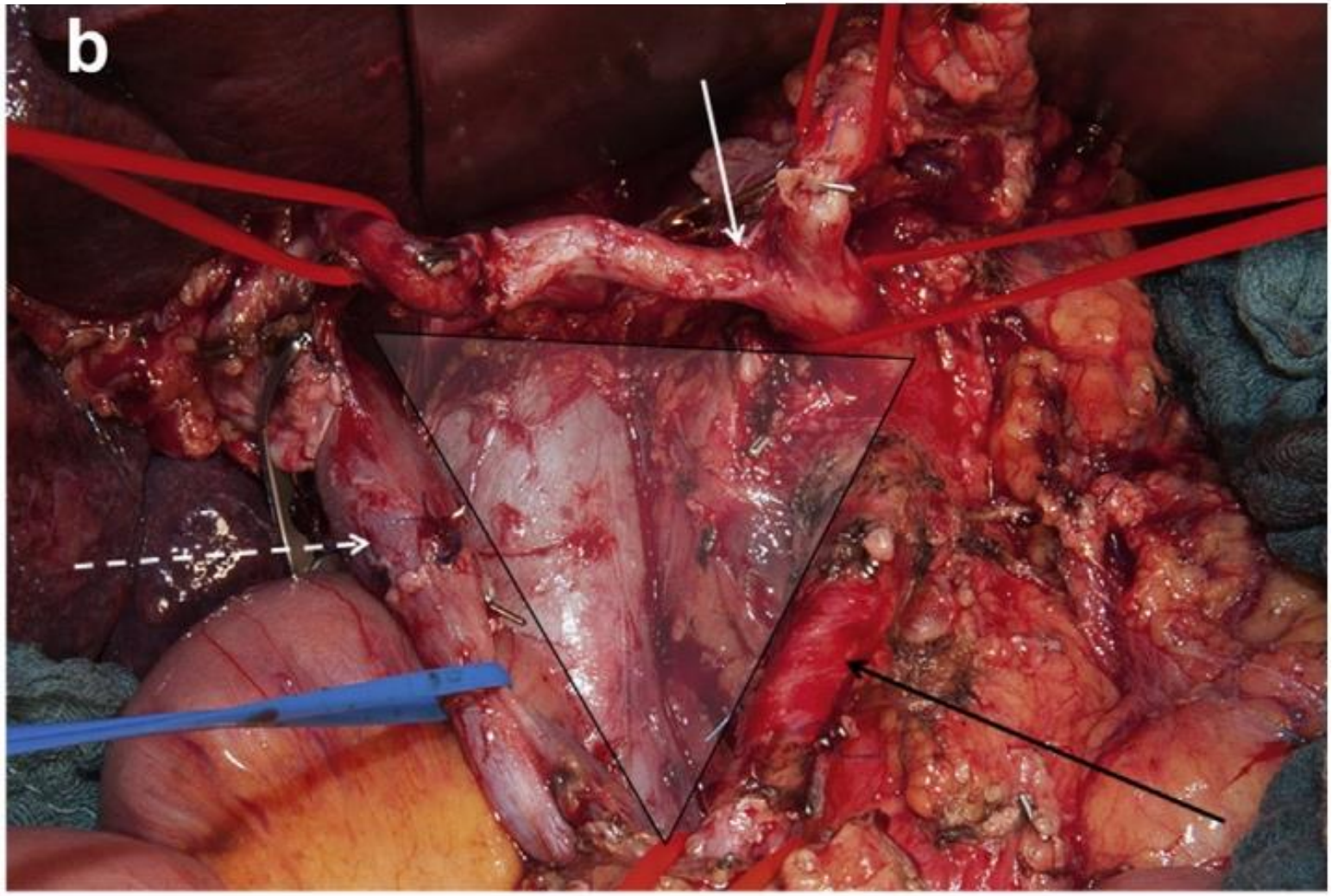


Chen JH, et al. World J Surg Oncol 2024;22:4

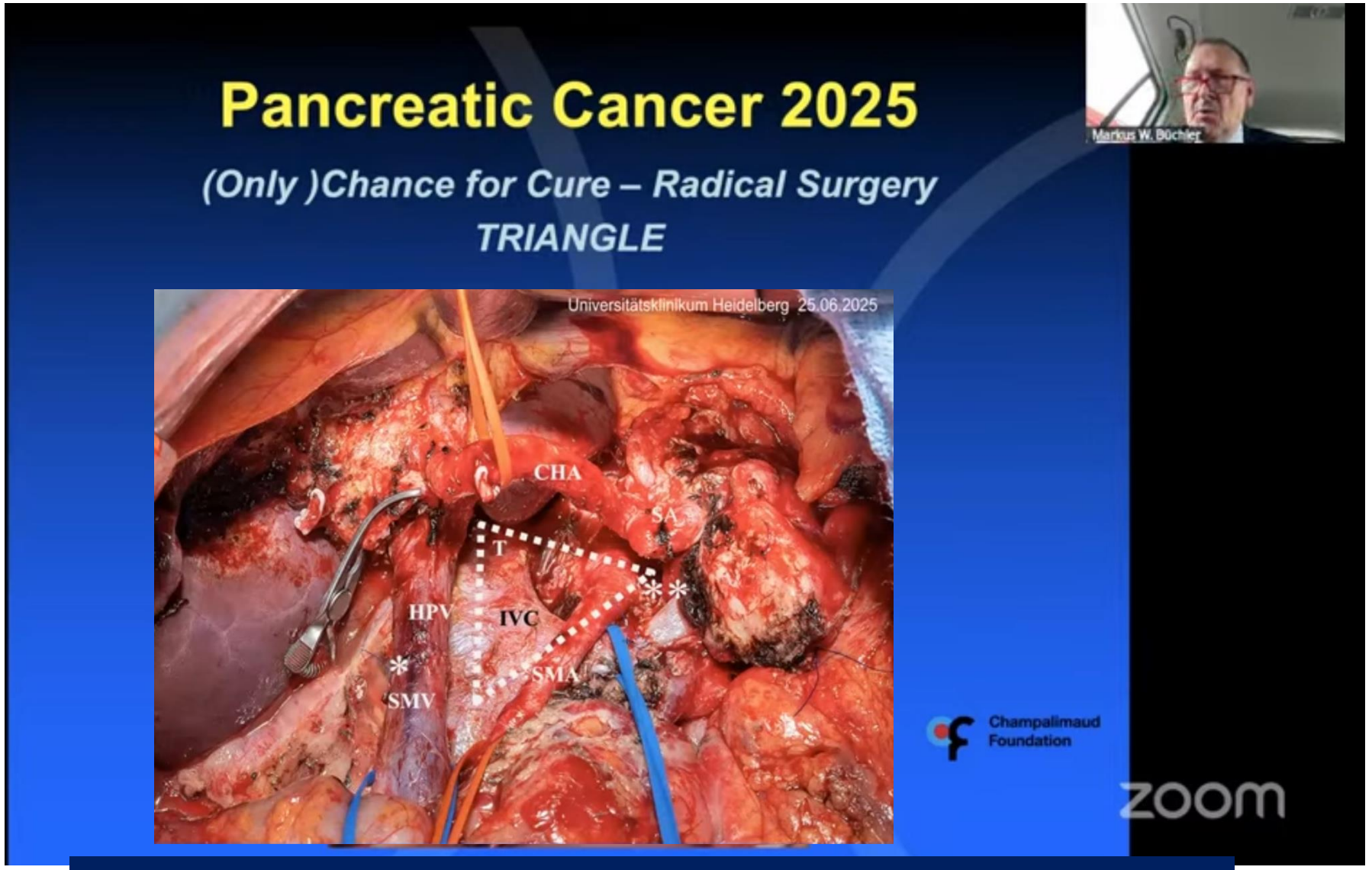
http://dx.doi.org/10.1016/j.hpb.2017.07.007 HPB

ORIGINAL ARTICLE

The TRIANGLE operation – radical surgery after neoadjuvant treatment for advanced pancreatic cancer: a single arm observational study



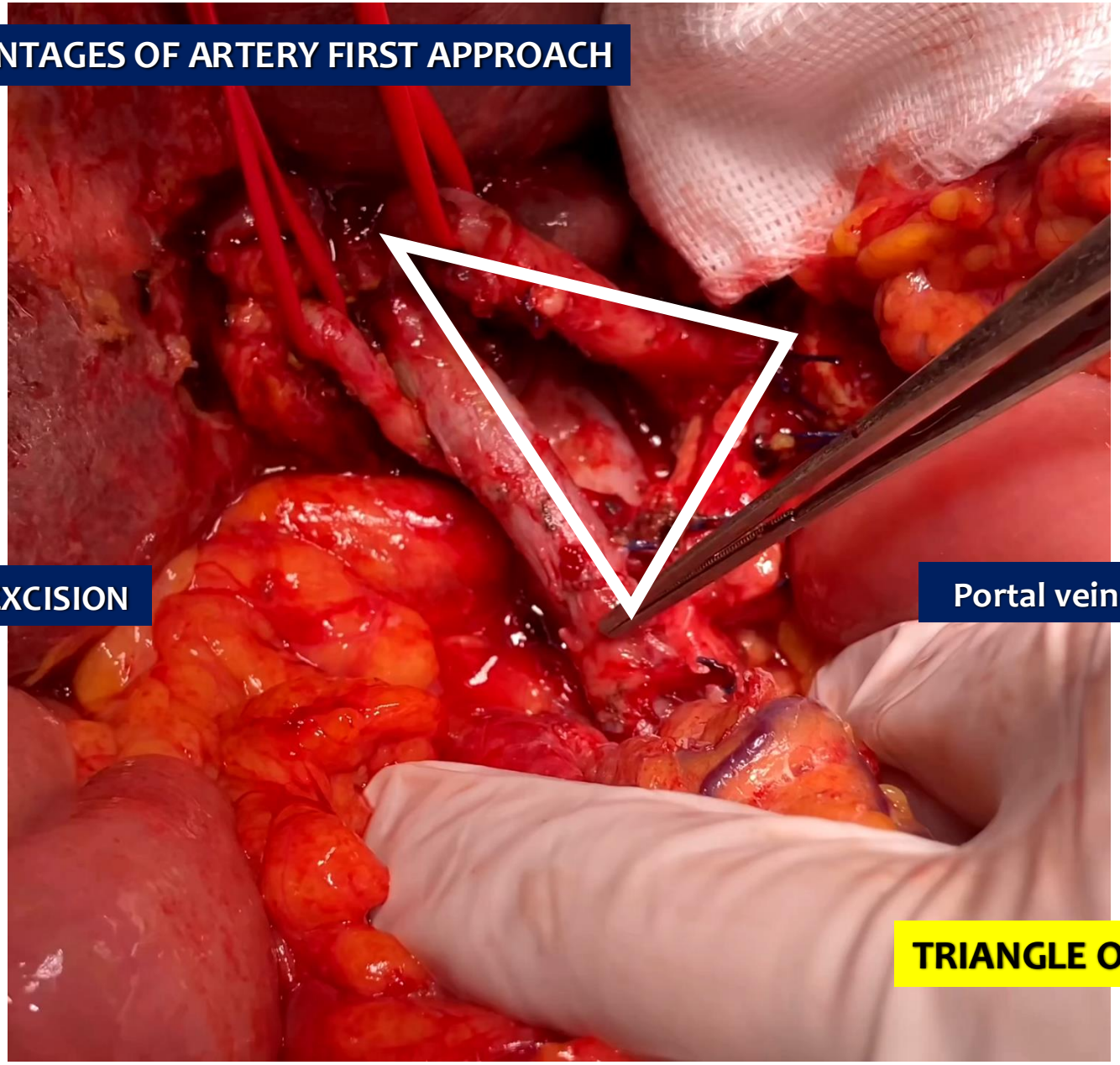
Hackert T, et al. HPB 2017



Pancreatic surgeon has to clean the TRIANGLE

Markus Buchler, 2025

ADVANTAGES OF ARTERY FIRST APPROACH

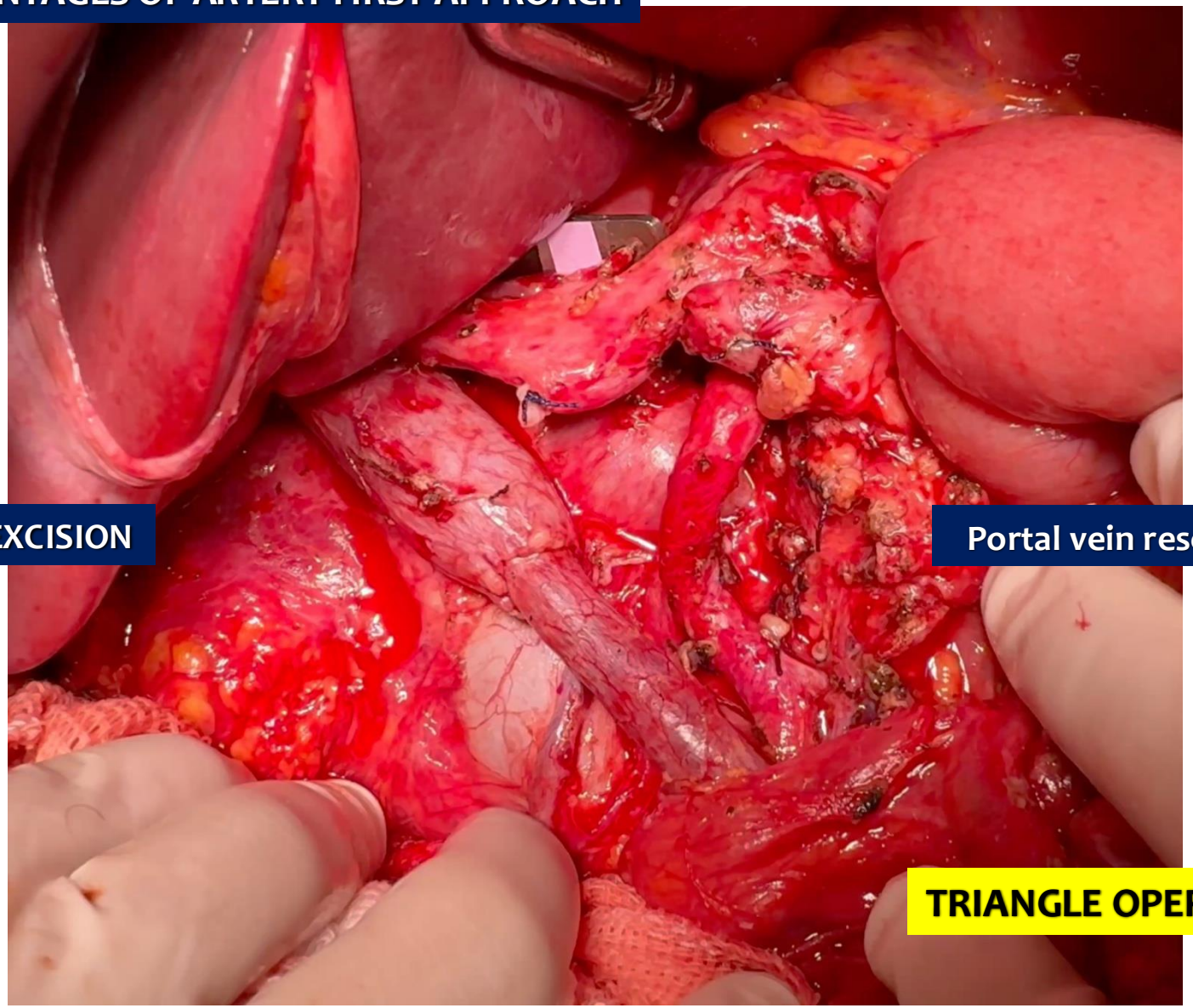


TOTAL MESOPANCREAS EXCISION

Portal vein resection

TRIANGLE OPERATION

ADVANTAGES OF ARTERY FIRST APPROACH

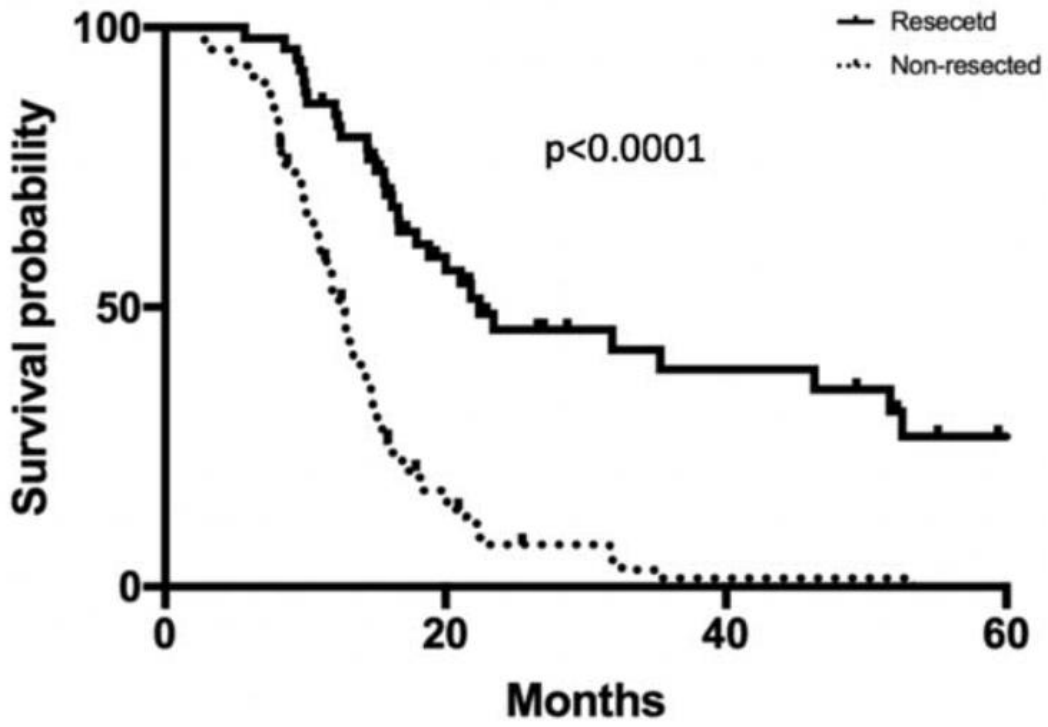


TOTAL MESOPANCREAS EXCISION

Portal vein resection

TRIANGLE OPERATION

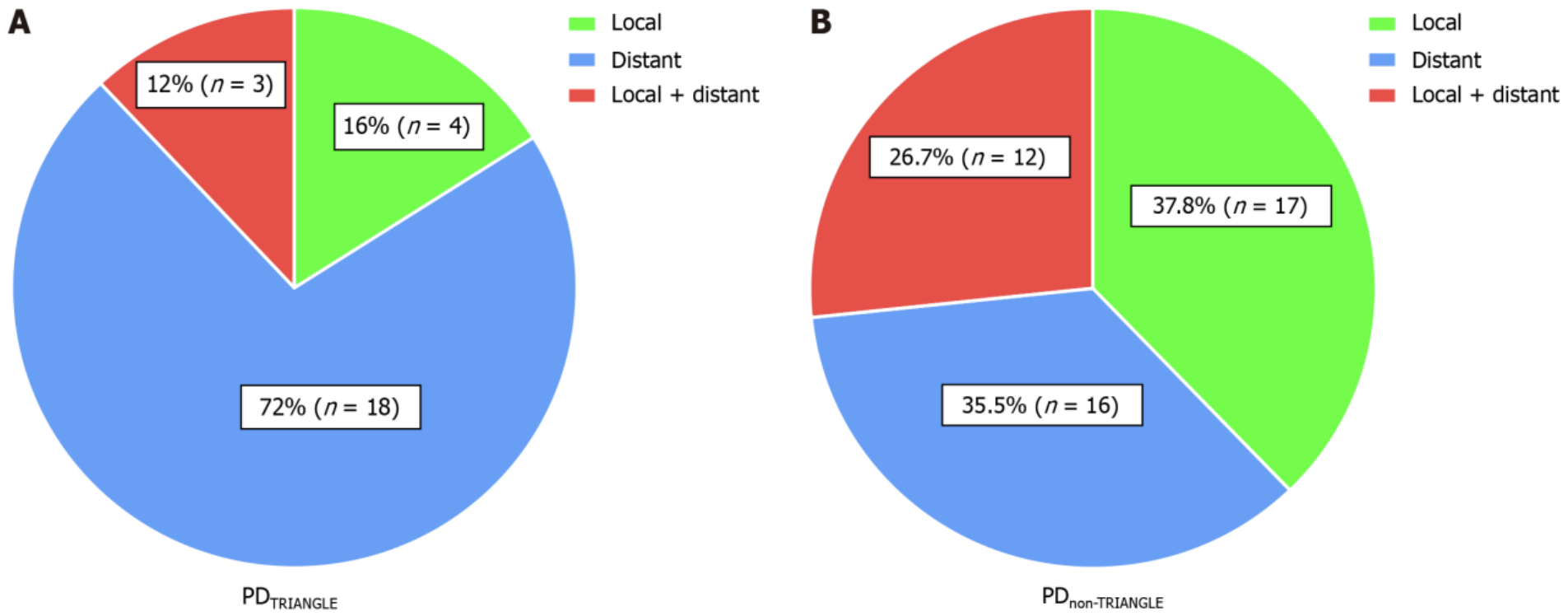
Surgery Improves Survival After Neoadjuvant Therapy for Borderline and Locally Advanced Pancreatic Cancer



Local radicality

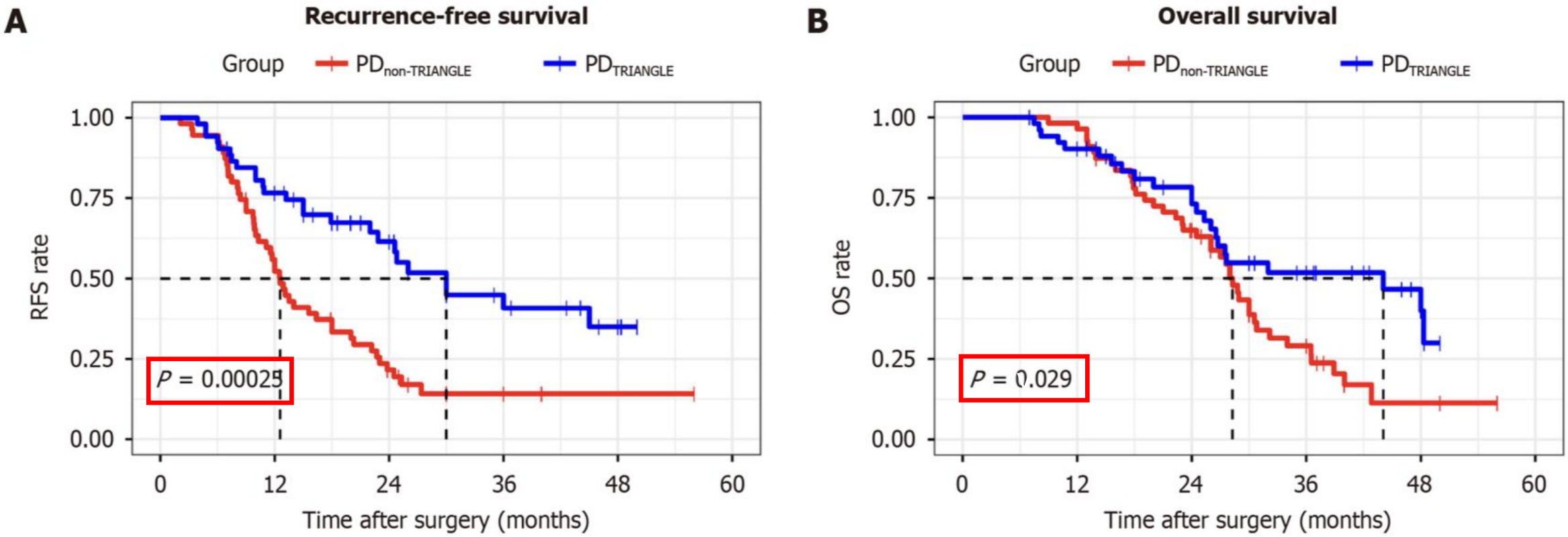
Rangelova E,et al. Ann Surg 2019

TRIANGLE OPERATION



Chen JH, et al. World J Gastrointest Oncol 2024; 16: 1773-86C

TRIANGLE OPERATION



Chen JH, et al. World J Gastrointest Oncol 2024; 16: 1773-86

http://dx.doi.org/10.1016/j.hpb.2015.11.009 HPB

REVIEW ARTICLE

A systematic review of the role of periadventitial dissection of the superior mesenteric artery in affecting margin status after pancreatoduodenectomy for pancreatic adenocarcinoma

James R. Butler[1], Syed A. Ahmad[2], Matthew H. Katz[3], Jessica L. Cioffi[1] & Nicholas J. Zyromski[1]

[1]Indiana University School of Medicine, Department of Surgery, Indianapolis IN, [2]The University of Cincinnati Cancer Institute, Cincinnati OH, and [3]Department of Surgical Oncology, The University of Texas MD Anderson Cancer Center, Houston, TX, USA

- R0 resection 16-79%
- SMA most often positive (15-45%)
- Positive margin was associated with decreased survival.

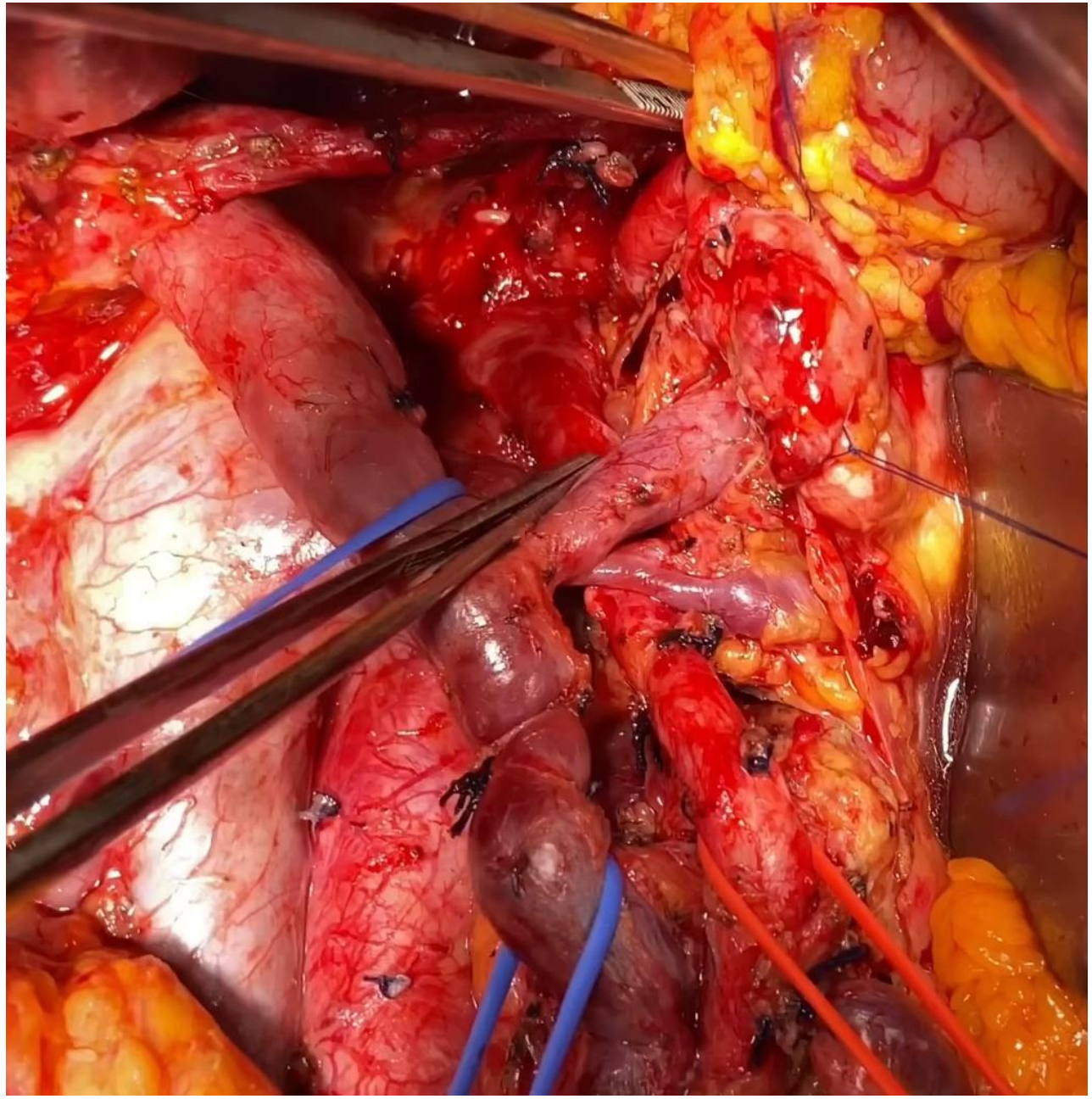
Conclusions: Margin positivity in resectable pancreatic adenocarcinoma is associated with poor survival. Inability to clear the SMA margin is the most common cause of incomplete resection.

Butler JR, et al. HPB 2015

STATE OF THE ART

Pancreatoduodenectomy

- Total mesopancreas excision[1]
- "Artery first"[2]
- Level 3 dissection[3]
- "Triangle operation"[4]
- Extended resection[5]
  - +/- portal/SM vein
- Liver metastasis



1.Fernandes ES, et al. Langenbecks Arch Surg 2021
2.Inoue Y, et al. J Gastrointest Surg 2018
3.Niesen W, et al. Ann Gastroenterol Surg. 2019
4.Hackert T, et al. HPB 2017
5.Fernandes ES, et al. J Gastrointest Oncol 2023
6. Torres OJ, Zurich and Cape Town

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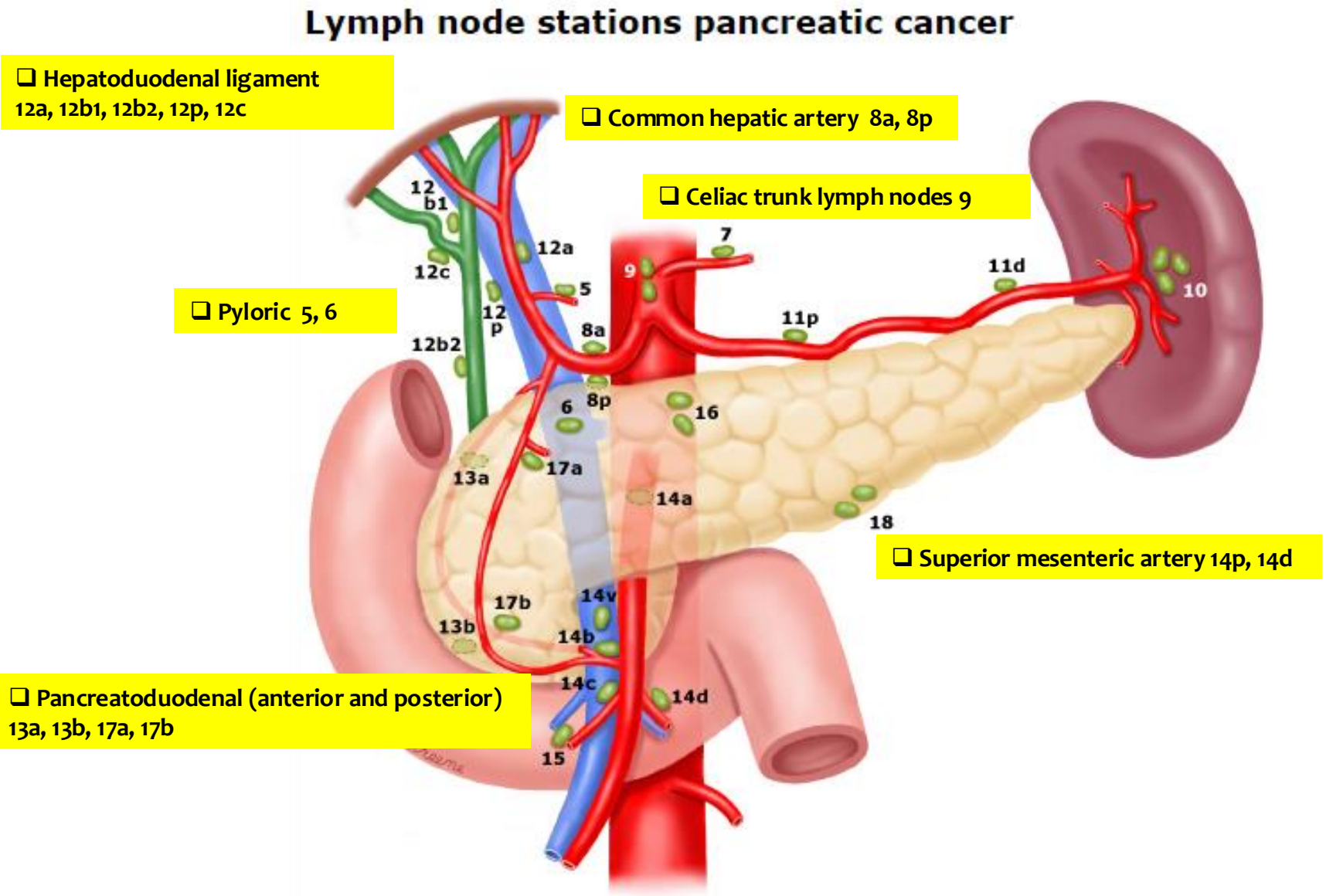
ARTERY FIRST

Fernandes ESM, et al. Langenbeck's Arch Surg 2021

LYMPHATICS



❑ Hepatoduodenal ligament
12a, 12b1, 12b2, 12p, 12c

❑ Common hepatic artery 8a, 8p

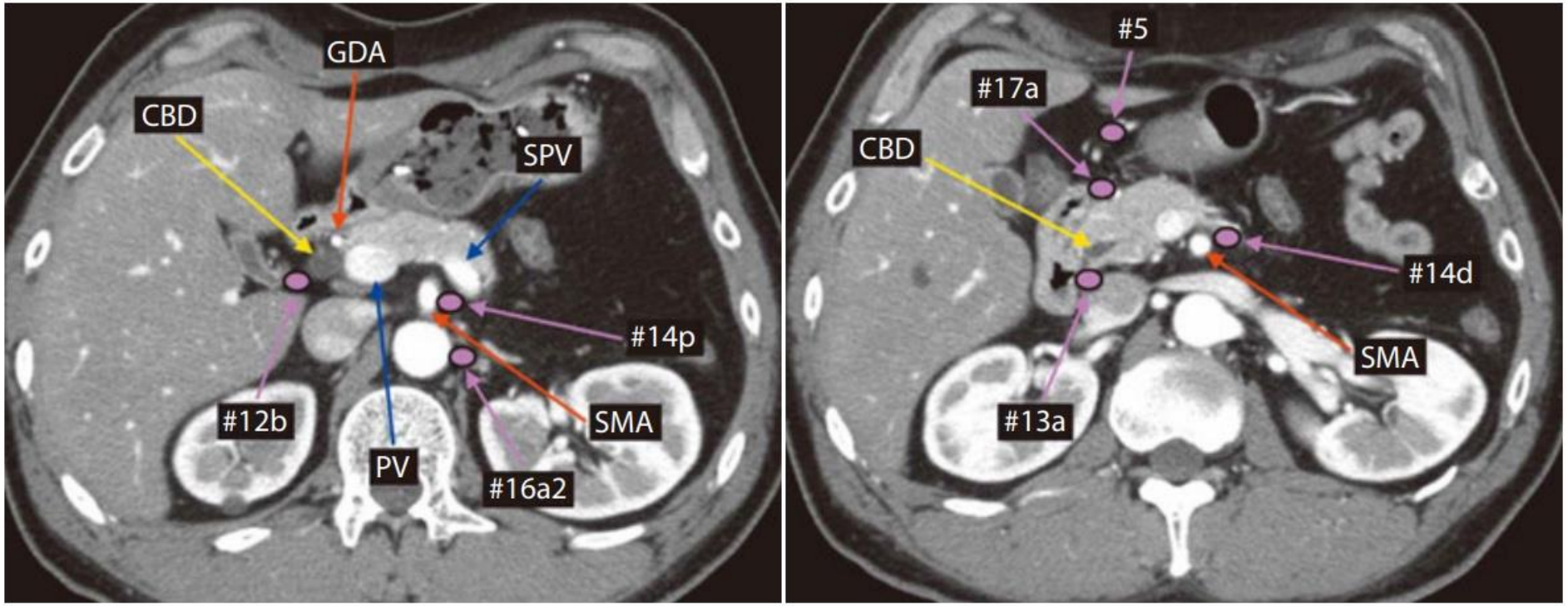
❑ Celiac trunk lymph nodes 9

❑ Pyloric 5, 6

❑ Superior mesenteric artery 14p, 14d

❑ Pancreatoduodenal (anterior and posterior)
13a, 13b, 17a, 17b

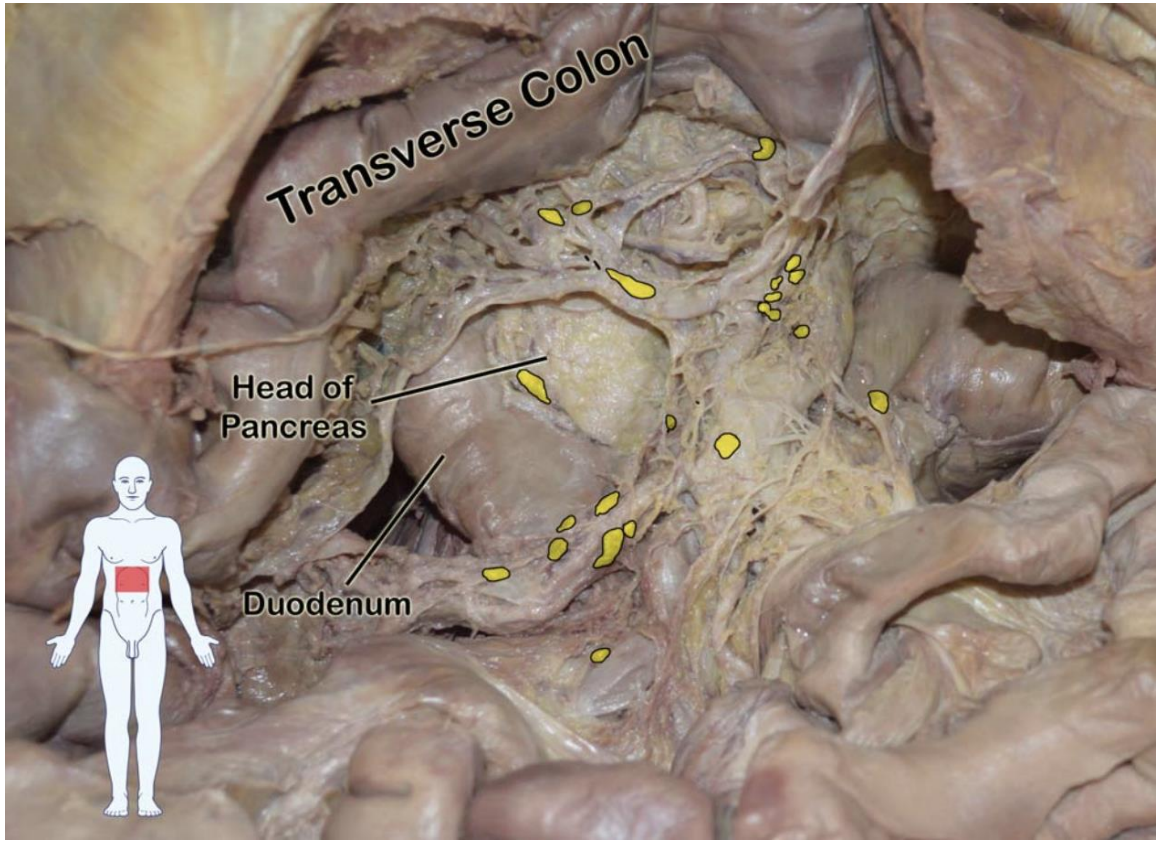
LYMPHADENECTOMY

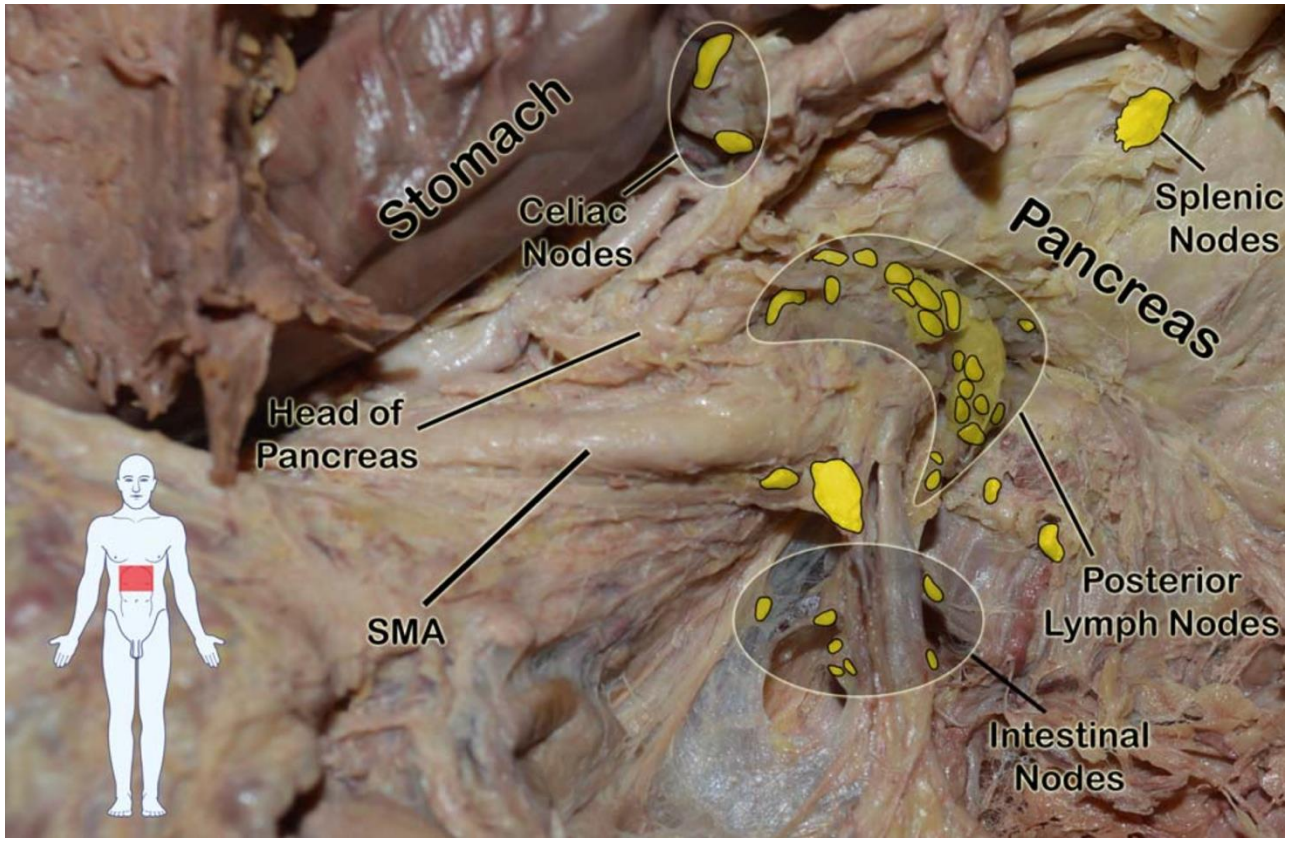


14p, 14d

Japan Pancreas Society – Fourth English Edition, 2017

LYMPHADENECTOMY





Cesmebasi A, et al. Clinical Anatomy 28:527–537 (2015)

ARTERY FIRST

.1007/s00268-020-05856-w

World Journal of Surgery

ORIGINAL SCIENTIFIC REPORT

Complete Lymphadenectomy Around the Entire Superior Mesenteric Artery Improves Survival in Artery-First Approach Pancreatoduodenectomy for T3 Pancreatic Ductal Adenocarcinoma

ARTERY FIRST

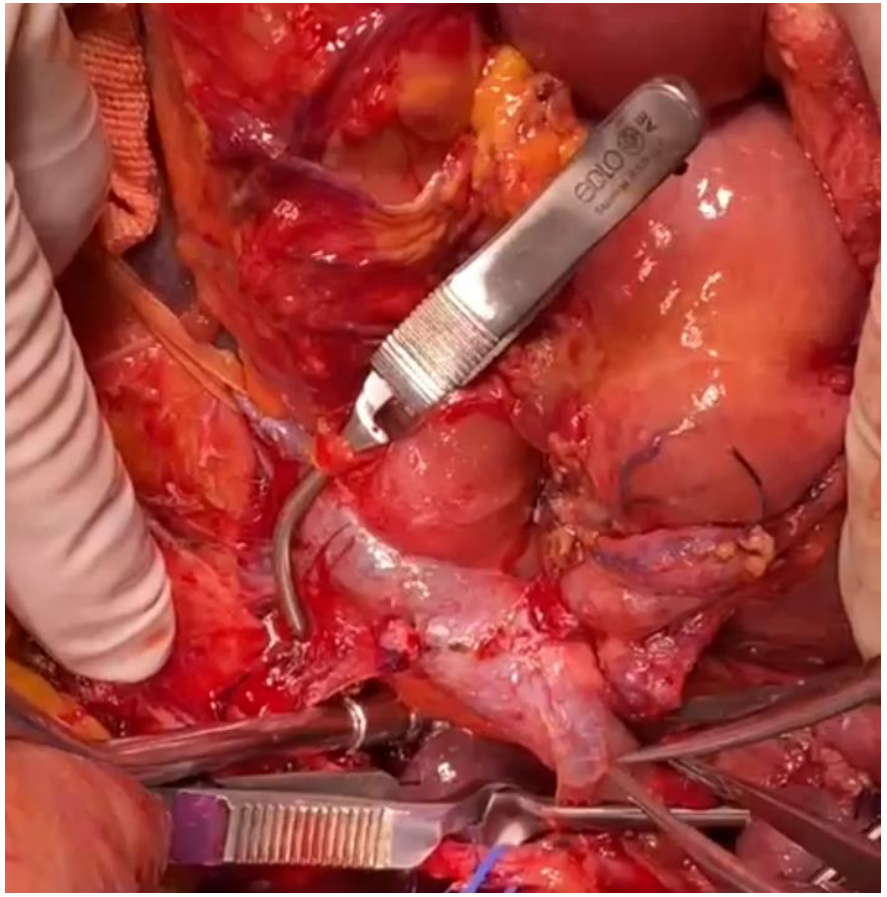
Table 2 Comparison of perioperative and oncological outcomes between the AFA-PD group and the conventional PD group

	AFA-PD group	Conventional PD group	*P*
	n = 45	*n* = 43	
Operative time, median (range), min	443 (390–497)	467 (414–530)	0.1312
Intraoperative blood loss, median (range), mL	811 (520–1150)	899 (720–1443)	**0.0210**
Transfusion, n (%)	19 (42.2)	22 (51.2)	0.5178
Portal vein resection, n (%)	12 (26.7)	13 (30.2)	0.8147
Postoperative complications, ≥ grade IIIa, n (%)	3 (6.7)	5 (11.6)	0.4794
Curative resection R0, n (%)	35 (77.8)	28 (65.1)	0.3423
No. harvested lymph nodes, median (range)	23 (14–37)	19 (12–22)	**0.0165**
No. harvested lymph nodes of #14p, median (range)	4 (2–5)	1 (0–3)	**< 0.001**
No. harvested lymph nodes of #14d, median (range)	4 (2–5)	2 (0–3)	**0.0146**
Lymph node metastasis, n (%)	27 (60)	30 (69.8)	0.3376

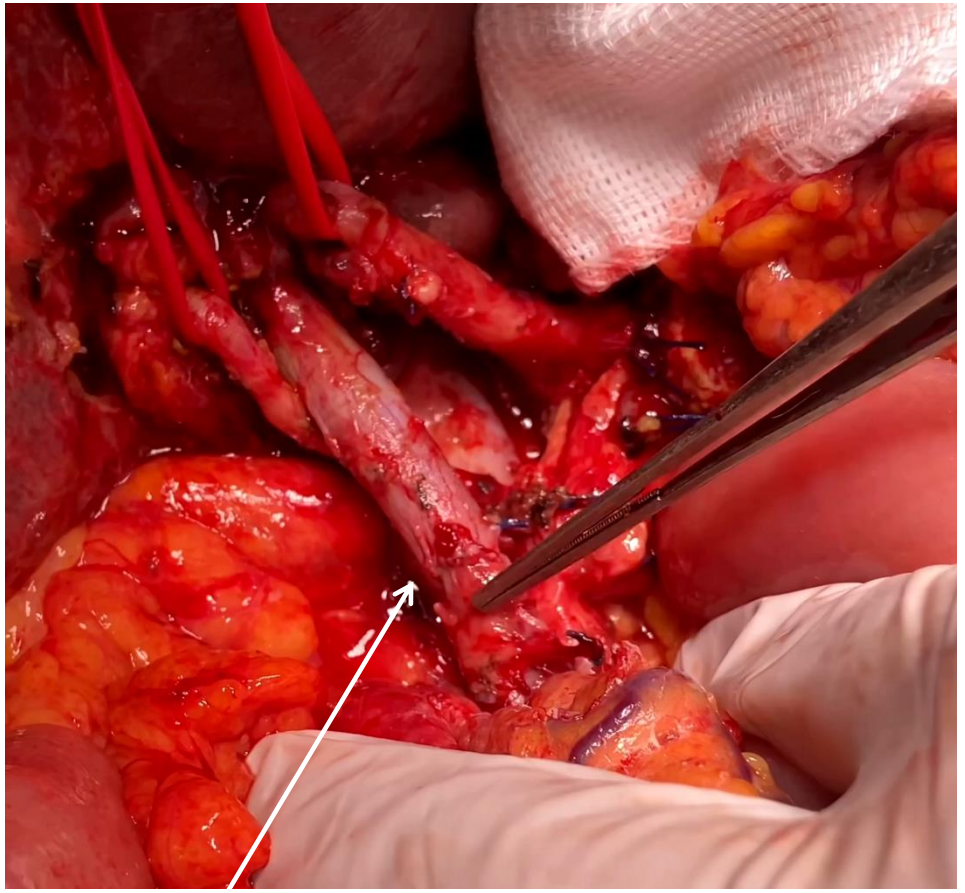
Bold values are statistically significant ($p < 0.05$)

AFA-PD - Artery first approach pancreatoduodenectomy

Kobayashi S, et al. World J Surg 2020

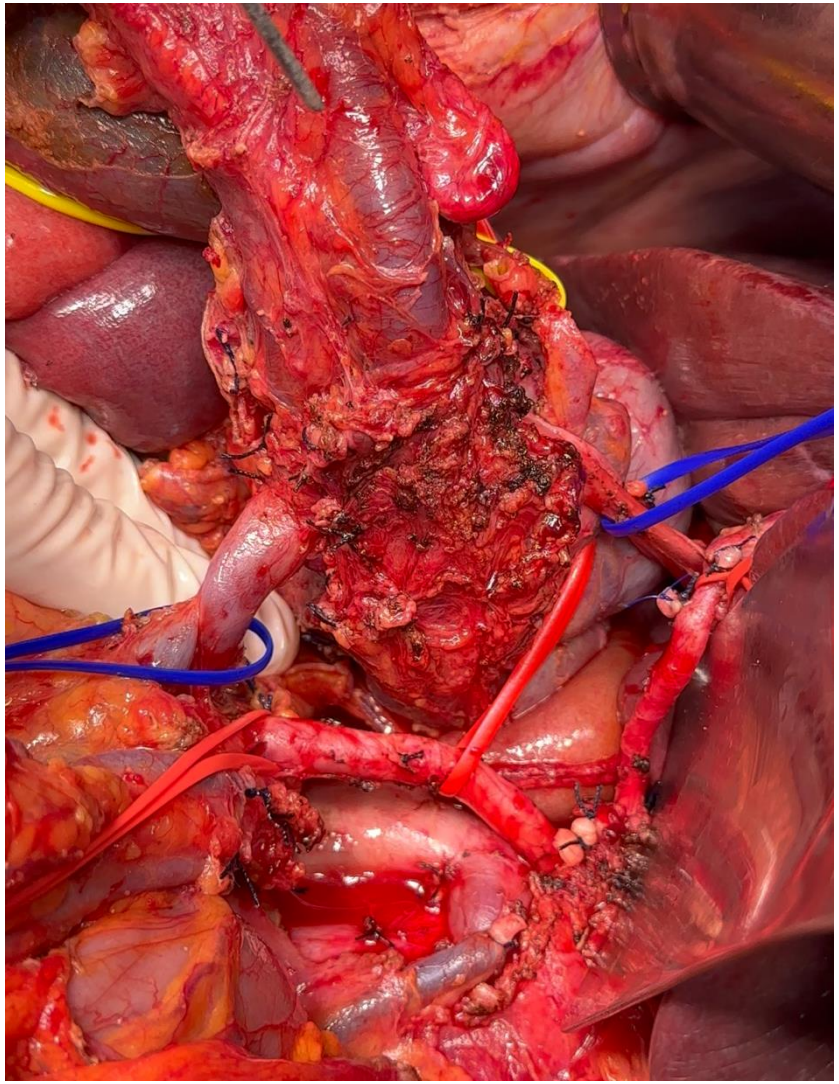


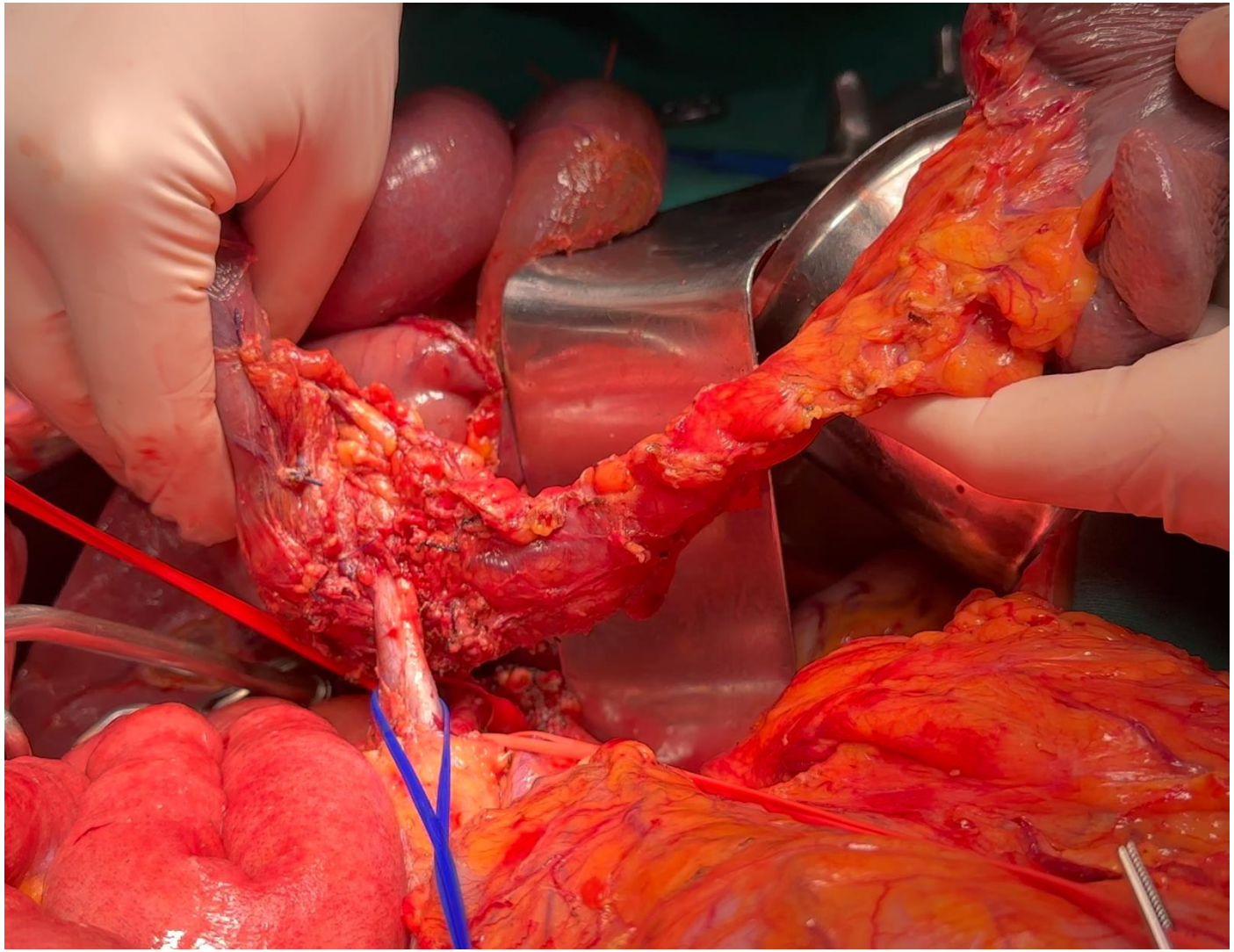
Portal vein resection



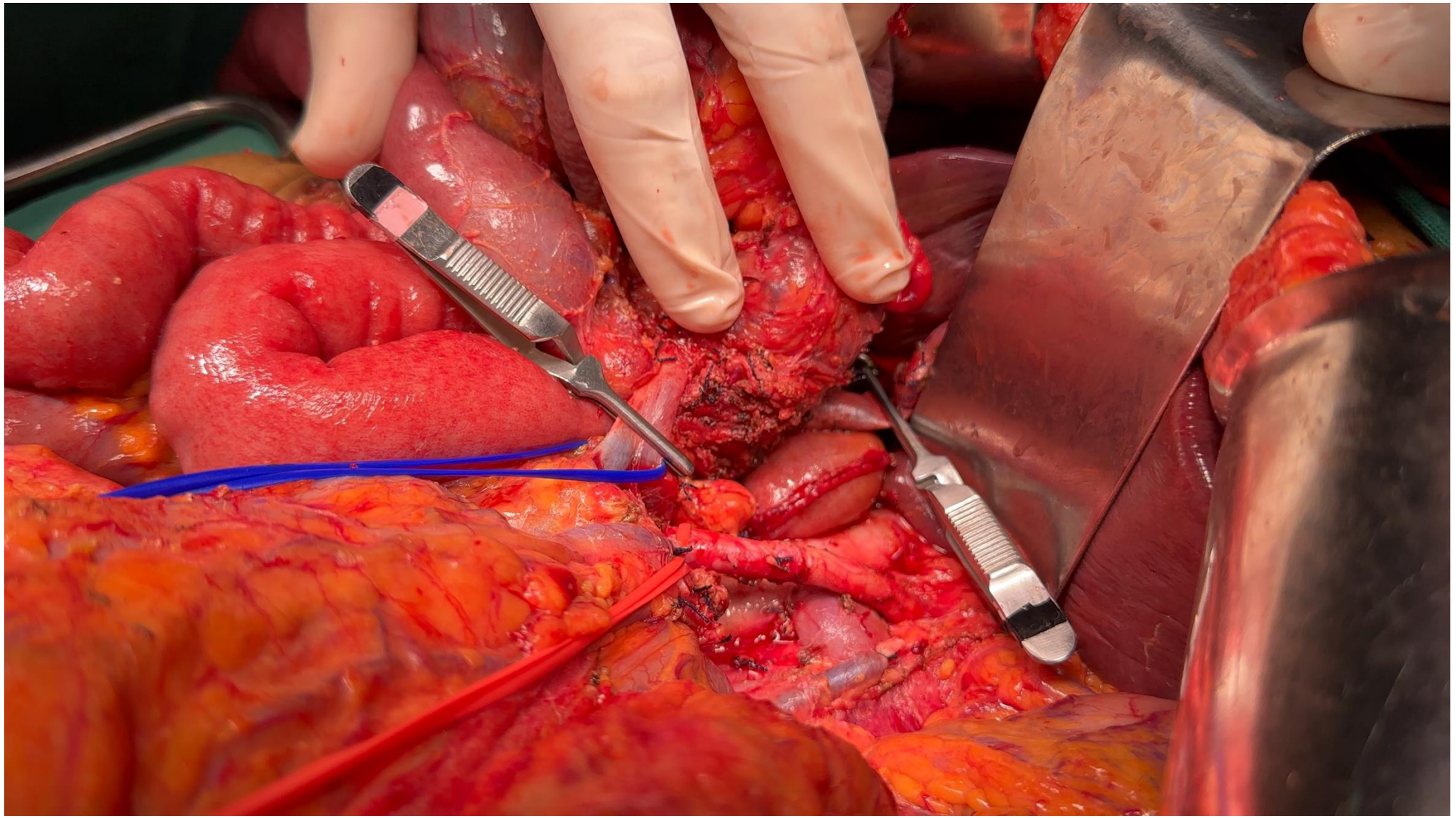
Portal vein anastomosis

Portal vein/superior mesenteric vein resection/reconstruction

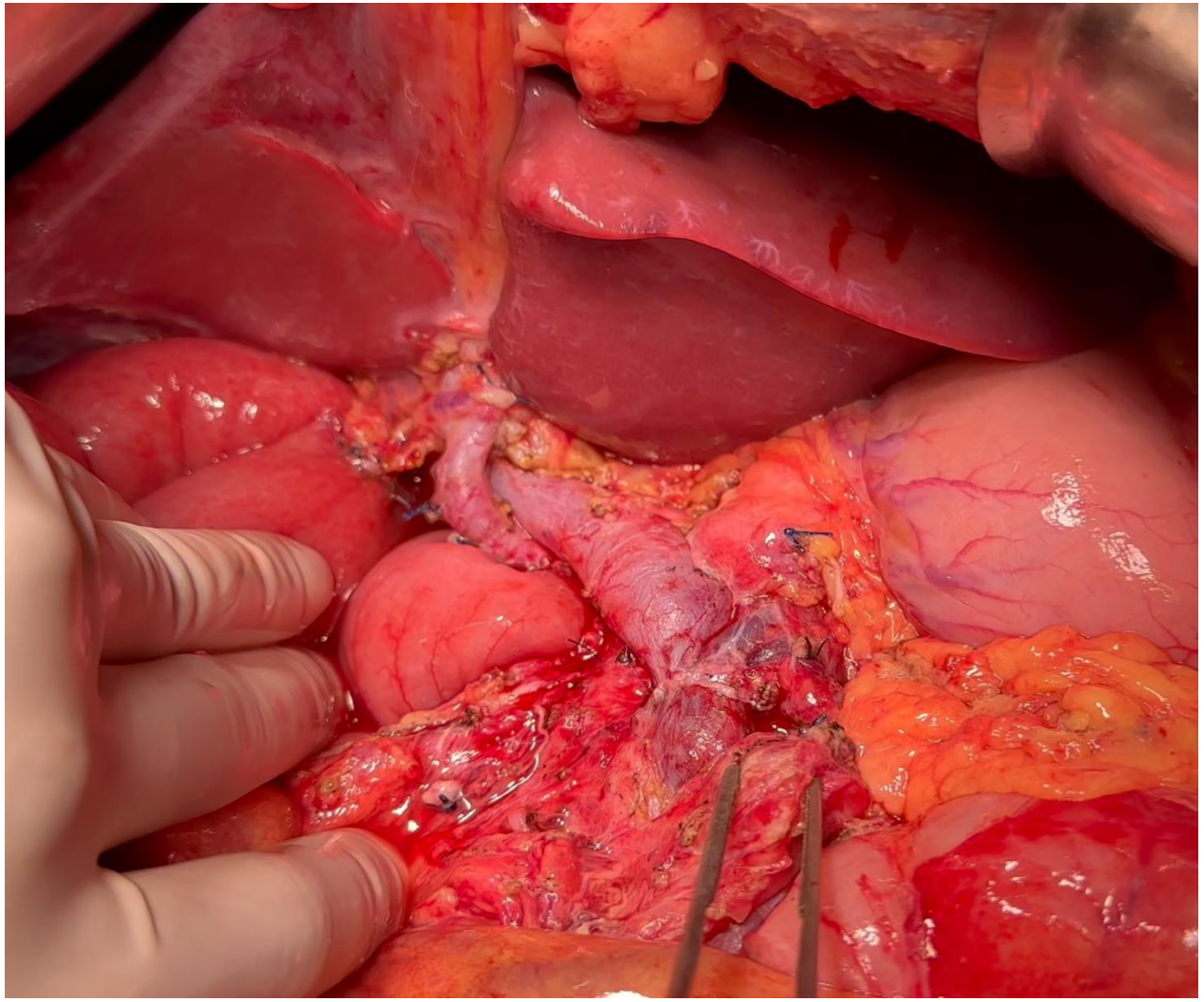




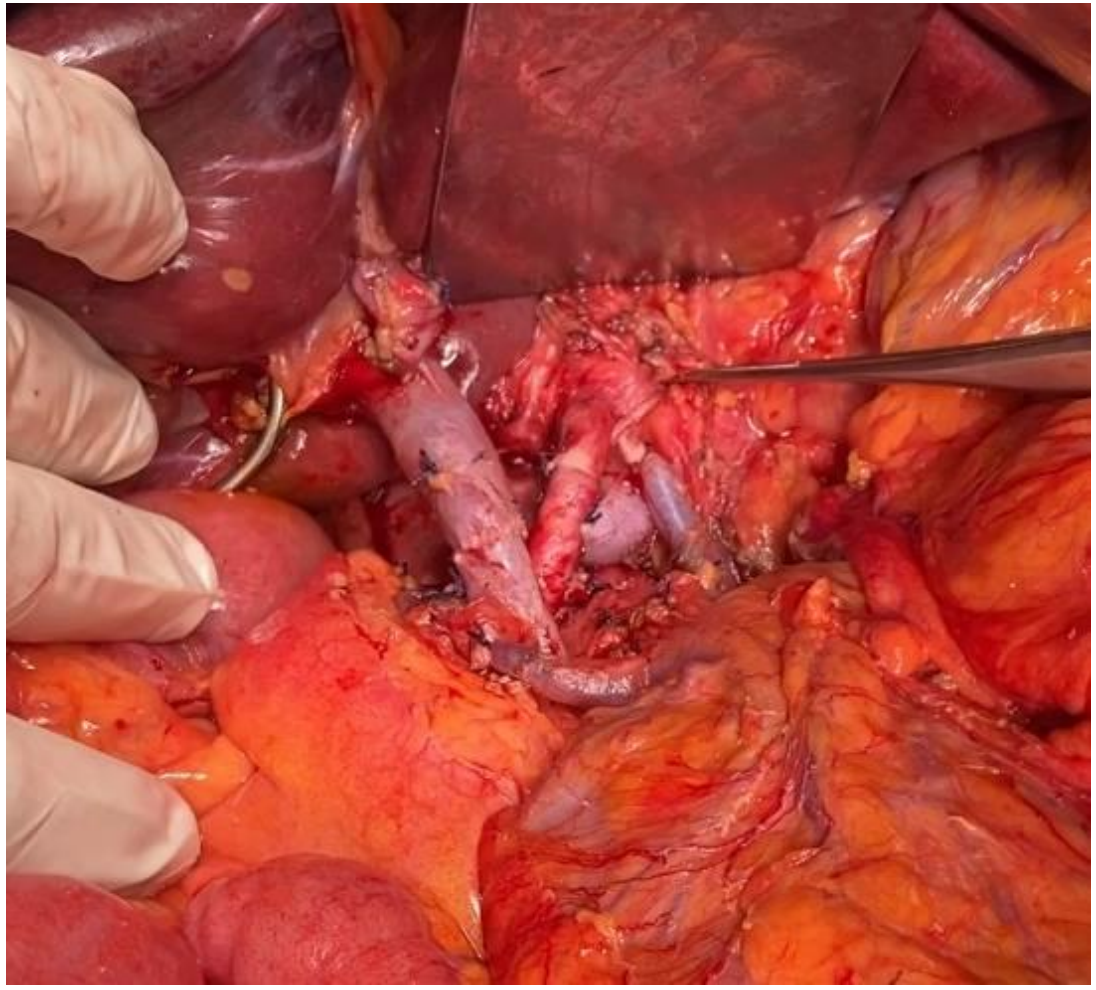
Portal vein/superior mesenteric vein resection/reconstruction

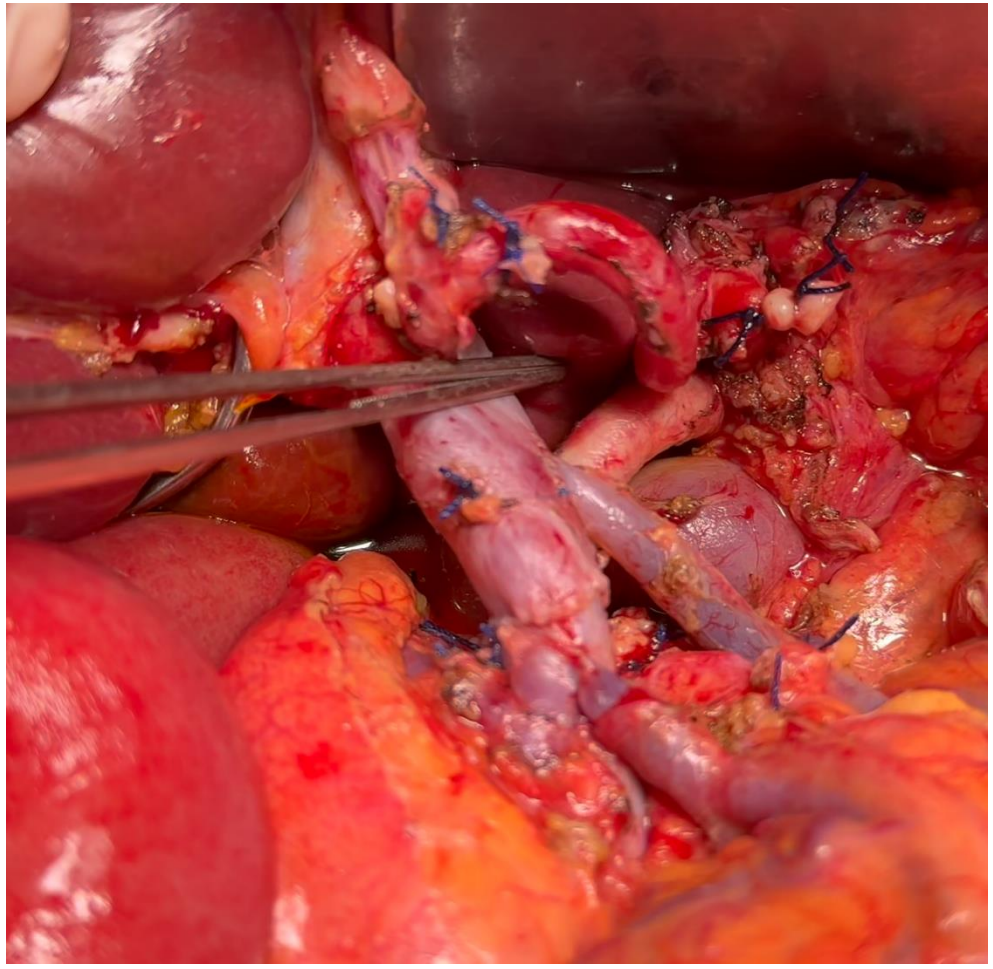


Portal vein/superior mesenteric vein resection/reconstruction

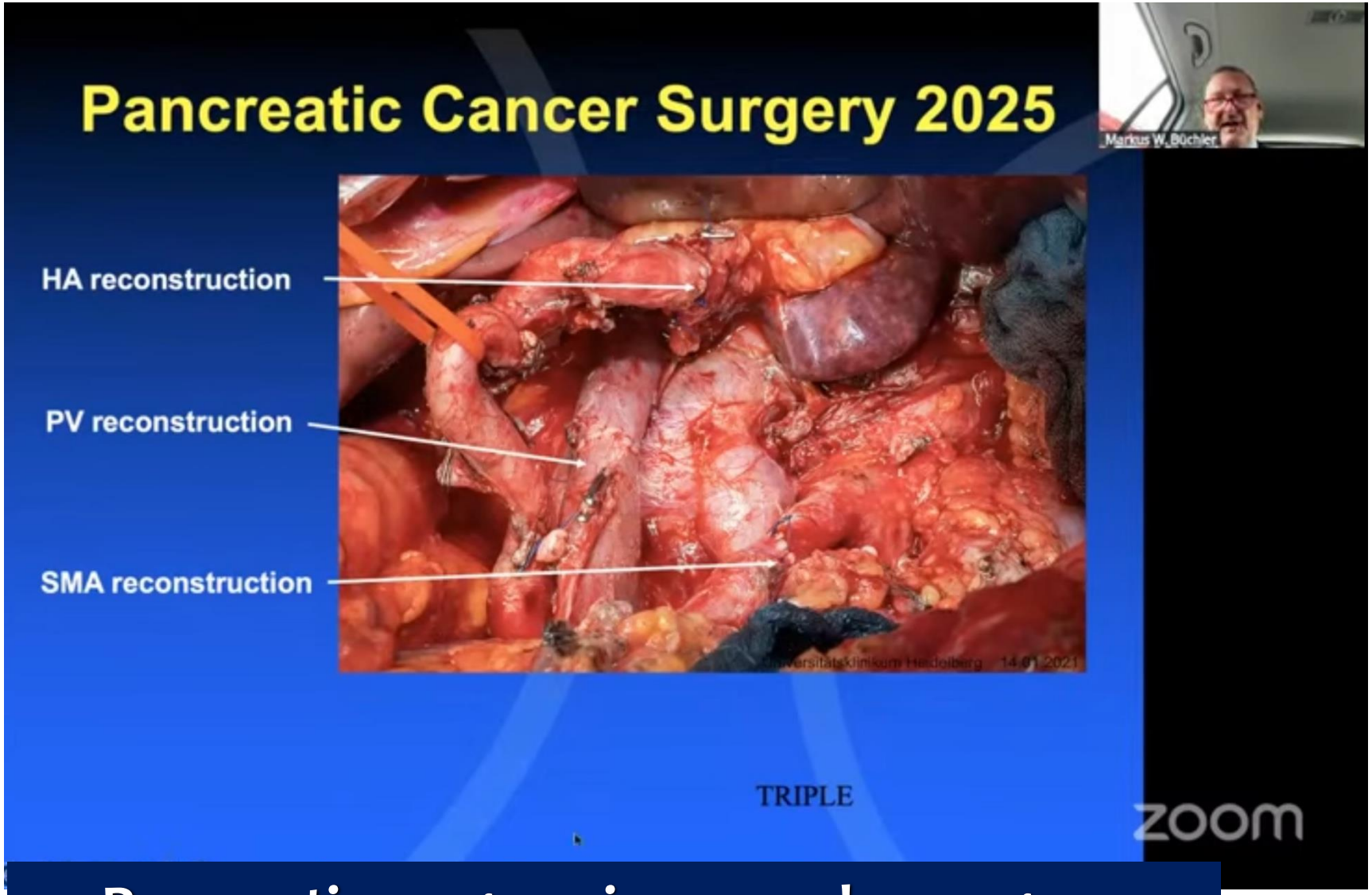


Portal vein/superior mesenteric vein resection/reconstruction





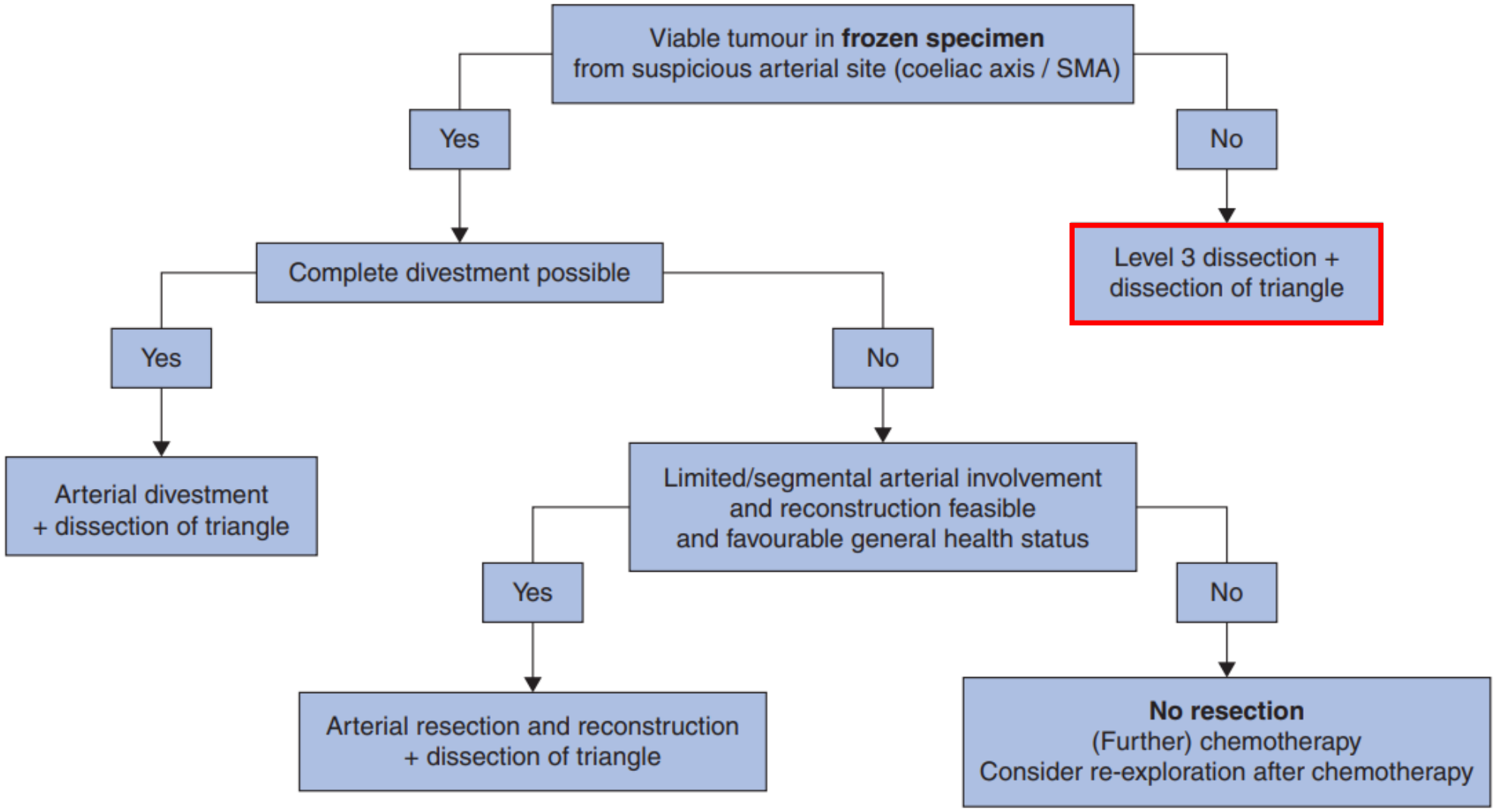
Portal vein/superior mesenteric vein resection/reconstruction



Pancreatic surgeon is a vascular surgeon

Markus Buchler, 2025

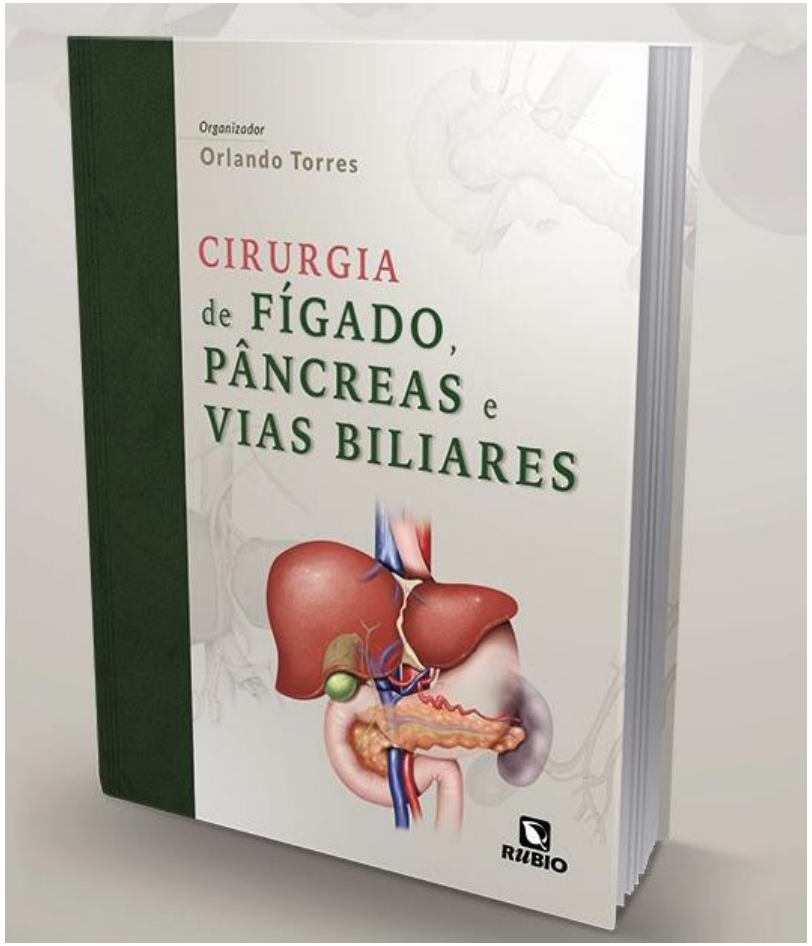
ESTADO DA ARTE



Schneider M, et al. BJS 2021; 108: 777–85

In spite of this problem, radical resection with adequate regional lymphadenectomy and radical resection around the large peri-pancreatic vessels is an important prerequisite for good oncological outcomes. There is ample evidence from recent studies performed in the context of high-quality radical surgery and modern adjuvant therapy that local radicality, defined by lymph node variables and by resection margin status data, has a profound impact on survival. In modern pancreatic surgery, radical resections can be facilitated and achieved by several techniques, including artery-first approaches, a level-3 dissection around the arteries, the TRIANGLE operation, and extended resections with resection of additional organs or vessels.

Niesen W, et al. Ann Gastroenterol Surg. 2019;3:464–75



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Obrigado!

Lençóis Maranhenses

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