Case Reports

Successful Laparoscopic Pancreaticoduodenectomy for Intraductal Papillary Mucinous Neoplasm: A Case Report and a Reliable Technique for Pancreaticojejunostomy

Yoshiharu Nakamura, Satoshi Matsumoto, Masato Yoshioka, Tetsuya Shimizu, Kazuya Yamahatsu and Eiji Uchida

Surgery for Organ Function and Biological Regulation, Graduate School of Medicine, Nippon Medical School

Abstract

Like other forms of laparoscopic surgery, laparoscopic pancreaticoduodenectomy (Lap-PD) is a minimally invasive procedure that can greatly reduce bleeding during surgery. We performed Lap-PD for a case of intraductal papillary mucinous neoplasm. To remove the resected tissue from the body, we made a small incision directly above the line of transection of the distal pancreas (the cut stump). This procedure requires complex reconstructive procedures, which we performed through the same small incision. All reconstructive procedures, except for hepaticojejunostomy, were performed under direct visualization; hepaticojejunostomy was performed laparoscopically. The reconstructive surgery was effective and was as safe as open abdominal surgery. We also discuss the value of using an endoscopic linear stapler for Lap-PD pancreatic transection, to reduce extravasation of pancreatic fluid into the abdominal cavity during the resection of tumors involving the pancreatic ducts, such as intraductal papillary mucinous neoplasm.

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Introduction

A relatively large number of laparoscopic pancreaticoduodenectomies have recently been reported in Asia, Europe, and North America12. Reports indicate that, like other forms of laparoscopic surgery, laparoscopic pancreaticoduodenectomy (Lap-PD) minimizes intraoperative bleeding12. This technique thus appears to be a useful form of minimally invasive surgery.

However, pancreaticoduodenectomy requires a minimum of 3 reconstructive procedures (pancreaticojejunostomy, hepaticojejunostomy, and gastrojejunostomy). The possible postoperative complication of pancreatic fistula is a real concern when any anastomosis is performed between the pancreas and gastrointestinal tract. The possibility of pancreatic fistula makes Lap-PD both technically...
and psychologically challenging for the surgeon.

In addition, intraoperative time is longer for Lap-PD than for open pancreaticoduodenectomy (open-PD). This difference is of particular concern in cases of neoplastic lesions that affect the pancreatic duct, because tumor cells from the neoplastic lesion may be present in the pancreatic fluid within the pancreatic duct and may leak into the abdominal cavity during surgical resection.

In this article we will discuss the usefulness of endoscopic linear staplers in pancreatic transection during Lap-PD procedures for intraductal papillary mucinous neoplasms (IPMNs) and will describe our procedures for reconstruction.

Case

The patient was a 62-year-old Japanese man 172 cm tall and weighing 56.6 kg (body mass index, 19.1 kg/m²). The patient had been treated for 10 years with insulin for diabetes. The family medical history was unremarkable. There was no history of alcohol or tobacco use.

Six months before diagnosis, the patient began to have irregular episodes of upper abdominal pain and back pain. The pain resolved without treatment but began to recur with increasing frequency. The patient was seen by a physician, who detected a cystic lesion at the head of the pancreas and referred the patient to our department. Imaging studies showed a cystic lesion with a maximum diameter of 3.6 cm in the head of the pancreas. In the head of the pancreas the main pancreatic duct was noted to be slightly and abnormally dilated and to communicate with the cyst through the branching pancreatic duct (Fig. 1). No mural nodules were detected within the cyst. No other disease was noted within the abdominal cavity. Symptomatic IPMN was diagnosed, and Lap-PD surgery was scheduled.

Surgical Procedures

The patient was immobilized in a supine position with the lower limbs apart. The scopist stood between the patient’s lower limbs, and the surgeon moved to the patient’s left or right side as needed. Laparoscopy was performed with a flexible scope, with pneumoperitoneal pressure set at 7 to 10 mm Hg. Figure 2 shows postoperative wounds and trocar placement.

All resection procedures including regional lymphadenectomy were performed laparoscopically. The posterior surface of the pancreas was detached from the superior mesenteric vein, the portal vein, the common hepatic artery, and the splenic vessels, from the neck of the pancreas to approximately 3 cm to the left of the planned cut line of the pancreas (tunneling). For pancreatic transection, we used an endoscopic linear stapler to stop extravasation of pancreatic juice from within the pancreatic duct and to prevent bleeding from the pancreatic parenchyma. Immediately after pancreatic transection, pneumoperitoneum was discontinued. A small incision (4 cm) was made directly above the cut stump of the distal pancreas, and a wound protector was positioned over the incision. Stay sutures were placed, with 1 needle used for each side of the resected stump. The sutures were then pulled upwards, and the pancreatic stump was easily pulled through the incision (Fig. 3a). The staples in the main pancreatic duct were removed with mosquito Péan forceps, and the cut portion of the

Fig. 1 Magnetic resonance cholangiopancreatography showed a cystic lesion, maximum diameter 3.6 cm, in the head of the pancreas. In the head of the pancreas the main pancreatic duct was noted to be slightly and abnormally dilated and to communicate with the cyst through the branching pancreatic duct (arrow).
pancreaticojunostomy, gastrojejunostomy, and Braun anastomosis were performed under direct visualization through the small incision above the distal pancreatic stump. The hepaticojejunostomy was performed laparoscopically.

For pancreaticojunostomy and gastrojejunostomy, the surgeon stood on the patient’s right side and used the small incisions that had previously been used for tissue removal. Pancreaticojejunostomy was performed with the Kakita method, just as for open PD. A curved 3-0 polygalactin needle was used to place interrupted sutures for end-to-side anastomosis. We were able to pull the pancreatic stump to the small opening (Fig. 3a, b). Thus, suturing of the pancreas, including direct anastomosis between the jejunal wall and the pancreatic duct, was performed under direct visualization (Fig. 3c). Sutures were tied directly with the fingers, which allowed the surgeon to proceed with increased confidence.

For gastrojejunostomy with Braun anastomosis, we used the same incision. The stomach and jejunum were drawn outside the body, and an endoscopic linear stapler was used for anastomosis under direct visualization.

Operating time was 557 minutes, and intraoperative blood loss was 50 mL.

Histopathologic Examination

Epithelial findings of papillary proliferation with atypia were noted in the cystic wall, branching pancreatic duct, and the main pancreatic duct (Fig. 4). These findings were diagnosed as dysplasia, rather than as cancer.

Postoperative Clinical Course

The patient began walking on postoperative day 2. First passage of gas was noted on postoperative day 3, and oral food intake was started. Laboratory studies showed that the level of C-reactive protein peaked at 7.4 mg/dL (normal <0.3 mg/dL) on postoperative day 3. Discharge was delayed because of an earthquake, so the patient remained in the hospital for 33 days after surgery. However, no
Fig. 3 An endoscopic linear stapler was used for pancreatic transection to stop the extravasation of pancreatic juice from within the pancreatic duct and to prevent bleeding from the pancreatic parenchyma. Immediately after pancreatic transection, pneumoperitoneum was discontinued. A small incision (4 cm) was made directly above the cut, and the incision was covered with a wound protector. Stay sutures were placed, with 1 needle used for each side of the cut stump. The sutures were then pulled upwards, and the stump was easily removed through the incision (a). The staples in the main pancreatic duct were removed with mosquito Péan forceps, and the cut portion of the main pancreatic duct (arrow) was opened (b). A drainage tube for pancreatic juice (paired arrows) was placed in the main pancreatic duct and connected so that the pancreatic juice would drain outside the body (c). The pancreas was sutured under direct visualization, as in traditional open pancreaticoduodenectomy (e).

Fig. 4 The main pancreatic duct showed papillary proliferation with atypia (hematoxylin-eosin stain, ×200).

complications, including complications of pancreatic fistula, were noted.

Discussion

Lap-PD ordinarily requires a relatively large surgical incision to permit the removal of the resected tissue. Our Lap-PD technique is characterized by a small incision (4 to 5 centimeters). This small incision is feasible because the incision for removal of resected tissue is positioned directly over the distal pancreatic cut. Following resection, anastomosis between the pancreas and gastrointestinal tract can be performed by direct visualization through the same incision². Although the pancreas is a retroperitoneal organ, the neck and body of the pancreas lie in front of the spinal column. They are thus displaced forward, close to the abdominal wall. As a result, the drainage tube
for pancreatic juice can be inserted into the pancreatic duct through a small incision, and suturing and ligation for pancreaticojejunostomy can be performed under direct visualization through the small incision. This enables the surgeon to perform anastomosis with as much confidence as in open PD. In contrast, the common hepatic duct is located in the right hypophrenium and is generally some distance from the abdominal wall. Direct visualization is problematic, because a small incision cannot provide a satisfactory field of view for anastomosis. We thus use a laparoscope for hepaticojejunostomy.

Because few reports are available on long-term prognoses after Lap-PD, to date we have used this procedure only for lower bile duct carcinoma and cancer of the duodenal papilla having a TNM classification of T2 or below and for benign to low-malignant tumors in the pancreatic head. Noninvasive IPMN can be classified as a low-malignant pancreatic tumor and as a suitable indication for Lap-PD. However, a definitive differential diagnosis between adenoma and cancer may be difficult to achieve before or during surgery. Careful and deliberate surgical technique is thus required because cancer cells may be present in any pancreatic tumor. Because the IPMN tumor lies within the pancreatic duct, if the tumor cells become cancerous, then cancer cells can be found floating freely in the pancreatic juice within the pancreatic duct even in the case of noninvasive intraductal papillary mucinous carcinoma. Cases of pseudomyxoma peritonei have been reported after IPMN surgery, suggesting that mucosal fluid containing tumor cells may have leaked into the abdominal cavity during surgery. In pancreaticoduodenectomy, pancreatic juice can leak into the abdominal cavity from the time of the first cut into the pancreas until all resected tissue is removed and anastomosis of the pancreas and gastrointestinal tract is completed. We used an endoscopic linear stapler to cut the pancreas and closed the pancreatic stump to prevent extravasation of mucosal fluid from within the pancreatic duct into the abdominal cavity during subsequent surgical procedures. The endoscopic linear stapler was also available to reduce bleeding from the pancreatic stump.

References


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