

SHORT COMMUNICATION

New NCCN guidelines for locally advanced pancreatic cancer: New horizons in extending resectability

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Pancreatic ductal adenocarcinoma (PDAC) is the 4th leading cause of cancer-related death in the US, with a dismal 5-year relative survival rate of 8%, for all stages combined [1]. Surgical resection remains the mainstay of treatment but only 10-20% of the patients are candidates for curative surgery at the time of diagnosis [1,2] and 30-40% have Borderline Resectable Pancreatic Cancer or Locally advanced Pancreatic Cancer (LAPC) [2]. For resectable disease, an R0 resection is the goal of surgical extirpation, as a margin-positive resection is associated with poor prognosis [2,3].

There are restricted therapeutic options for patients with LAPC, which may include tumor ablation techniques as an adjunct to traditional chemotherapy, radiotherapy and surgical resection. Such techniques may be additionally used in patients with severe comorbidities, such as cirrhosis, who are not able to tolerate major surgery [4,5]. Previous research showed that a rather new ablative modality called Irreversible Electroporation (IRE), which was performed in patients with PADC, is safe and feasible [6-8]. Moreover, IRE may be used for margin accentuation purposes in patients with LAPC who undergo resection, with promising results [9,10]. However, presently, concerns exist in relation to the complications and technical expertise and IRE is currently recommended to be performed only in the setting of clinical trials [11-13].

There is substantial variation in management preferences of LAPC, mainly on the contraindications

to surgery and the propensity to consider exploration in LAPC. Of all available classifications (AHPBA/SSO/SSAT, MDACC, NCCN), NCCN seems to be superior in classifying patients as resectable and allowing the highest rates of R0 resection [14]. That is of paramount clinical importance, since recently NCCN guidelines were revised and extended the resectability criteria in patients with LAPC in those with tumor contacting with most proximal draining jejunal branch into SMV and the unreconstructible SMV/PV due to tumor involvement or occlusion [15].

From a surgical/technical standpoint, these changes might change the surgical practice of LAPC management. A recent study from Japan showed that proximal dorsal jejunal vein involvement in patients with LAPC was not related to worse overall outcomes and actually pancreaticoduodenectomy with concomitant jejunal vein resection was not linked to worse morbidity and mortality rates (15.7 and 0.8% respectively) [16]. Of interest, the incidence of clinically remarkable jejunal congestion was very low (around 3%) [16,17].

Overall, we think that due to the advancements in neoadjuvant therapy as well as the technical advances in pancreatic surgery, the extension of the resectability criteria in LAPC is reasonable. Surgeons and medical oncologists should be aware of the recent changes in NCCN guidelines and adjust their practice accordingly.

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