

Video Abstract Presentation

AB005. Laparoscopic distal pancreatectomy: learnings from my hepatopancreatobiliary training

Vittoria Vanessa Velasquez^{1,2}, Yoshihiro Miyasaka¹, Kohei Nakata¹, Yasuhisa Mori¹, Takao Ohtsuka¹, John Richard Nunez², Menandro Siozon², Catherine Teh², Masafumi Nakamura¹

¹Department of Surgery and Oncology Kyushu University Hospital, Fukuoka, Japan; ²Institute of Surgery St. Luke's Medical Center, Quezon City, Philippines

Background: Distal pancreatectomy is the most common laparoscopic procedure for the pancreas and has become standard in many institutions globally. Among ASEAN countries, the Philippines is still in its infancy when it comes to minimally invasive surgery for pancreatic lesions.

Methods: This video shows the technique for laparoscopic distal pancreatectomy (LDP) from my mentors at Kyushu University Hospital (KUH) in Japan, which has two decades of experience with excellent outcomes.

Results: Preoperatively, a dedicated HPB team reviews the MRI and CT scan (with 3D reconstruction) and discusses the proper approach. In LDP, the patient is placed in supine position initially then shifted to a semi-Fowler's position after all the ports are inserted (five ports); the

surgeon operates from the patient's right side. Whenever applicable, spleen-preservation is prioritized, either splenic vessel preserving or ligation (Warshaw). After exposing the pancreas, dissection is initiated at the superior border continuing towards the tail; splenic artery and vein are identified consecutively; dissection is further advanced at the inferior border (in some cases, the splenic vein can be exposed during this time); and finally lifting the pancreas from the retroperitoneum. For lesions where resection line is at the level of the portal vein, the common hepatic artery is separately identified and tagged from the splenic artery to prevent injury; at the same time, superior mesenteric and portal veins are also exposed. Tumor location is confirmed intraoperatively using laparoscopic ultrasonography. The pancreas is transected using a linear stapler after prolonged parenchymal compression. Lymph node dissection is limited to high-risk lesion or known malignancy. The specimen is placed in a bag and removed through the umbilical port. Lastly, a drain is positioned along the previous pancreatic bed near the resection line.

Conclusions: LDP is a safe and feasible technique that can be standardized and learned with proper mentoring and training.

Keywords: Laparoscopic distal pancreatectomy; pancreas; pancreatectomy; minimally invasive surgery

doi: 10.21037/ales.2018.AB005

Cite this abstract as: Velasquez VV, Miyasaka Y, Nakata K, Mori Y, Ohtsuka T, Nunez JR, Siozon M, Teh C, Nakamura M. Laparoscopic distal pancreatectomy: learnings from my hepatopancreatobiliary training. *Ann Laparosc Endosc Surg* 2018;3:AB005.