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WHICH TREATMENT IN CYSTIC TUMORS OF THE PANCREAS: CONSERVATIVE OR RESECTION

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A R T I C L E I N F O

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A B S T R A C T

Introduction: The cystic tumors are relatively rare, considered approximately 10% of all pancreatic neoplasms. Only 1% of all cystic pancreatic tumors are malignancies. Often asymptomatic onset, develop mechanical symptoms with their progressive growth, compressing adjacent anatomical structures The purpose of the study is to, through a retrospective analysis of our patients, evaluate the indications for treatment of cystic neoplasms of the pancreas.

Materials and Methods were evaluated retrospectively 13 patients (8 females, range 58-85 years) with pancreatic cystic neoplasms observed at the Surgery Unit colo rectal from 2007-14 Policlinico Catania, in addition to 11 patients (6 males females 5 range 60-75 years) from 2008 to 2015 observed at the II clinical Surgical Hospital of Catania the main features of imaging currently adopted for the diagnosis of pancreatic cystic neoplasms include localization, intralesional cysts pattern (unilocular oligocistica, polycystic appearance) , calcifications, communication with the main pancreatic duct or side ducts, thick septa, the presence of internal or mural nodules debris. The TNM staging of cancer in Group I in n 5 cases were in stage T2MoNo, in 7 cases in stage T3 M1NX.Nel Group II in n 9 cases T3MXNX stadium and the remaining cases T4MXNX.

Results In reference to the first group of 13 patients with pancreatic cystic neoplasms. In Codest group in each patient, was adopted a different clinical approach based on different criteria: age, comorbidity, imaging characteristics, symptoms, Vitain 8 cases expectation surgical treatment was chosen resection, while in the remaining 5 cases was preferred a more conservative approach. Treatment was performed in N 4 cases, a DPC, in n2 cases a body tail resection, in one case the total pancrasectomia. In group II consisting of 11 patients, was adopted a more aggressive clinical approach based on diversified resectability criteria were: the absence of invasion axis mesenteric portal, and the absence of MTS

Discussion Surgery is currently the only treatment with curative intent, despite the claims of Gudioronsson, Di Catalto and others on the need and usefulness of a Intervet resection (1.3) Codest treatment remains the gold standard for the treatment of pancreatic ca.

Conclusions In recent years the scintigraphic techniques at immaging regard diagnostics and stanging of pancreatic tumors have been innovative and have gained a major role.

INTRODUCTION

Pancreatic cancer, with his 5-year survival in 5% of cases, is the most lethal of cancers; the incidence has risen steadily since 1900 mainly in the US population, central europe Japan, India, Thailand, Singapore, Vietnam. (1,2,3,4) In Italy there are 600 new cases per year (4.49) ranks as the fifth most common cause of deaths, with higher incidence in men, and with an increased risk with increasing age. The cystic tumors are relatively rare, considered approximately 10% of all pancreatic neoplasms. Only 1% of all cystic pancreatic tumors are malignancies. Often asymptomatic onset, develop mechanical symptoms with their progressive growth, compressing adjacent anatomical structures (portal vein, bile duct, stomach, duodenum, nerves) in spite of the large literature on the clinical and diagnostic features of cystic neoplasms. (5,6,7,) The presence of acute pancreatitis, pancreatic pathology and familiarity for the duration of the same appears to be a major risk factor since it increases the risk of cancer of 16.5 times. In tropical pancreatitis, which occur at a young age, the risk of developing cancer is also high. Another important risk factor is cystic fibrosis, which is manifested by a functional failure of the pancreas; other factors are: age (well known exponential factor), smoking, diet (because of the presence of carcinogenic specific), diabetes (8). Finally, the female has the ovarian cancer association - pancreatic cystic neoplasia body tail. (9.10.) In the hereditary pancreas cancer we detect the presence of a genetic defect, which occurs in association with the presence of BRCA2 positive, due to the loss of normal protective system or inactivation of the gene coattivato in the repair of DNA in charge of 'onset tumor. Currently there are at least 4 altered genes responsible for cancer: the K-RAS found mutated in 85% of pancreatic ca (4) and ductal pancreatic lesions; Genes suppressor P53, P16 and DPC4. They through the loss of function are involved in (10) pancreatic

carcinogenesis with a percentage of 76% of cases in P53 (11,12,13), in 100% of cases in P16 inactive (14,15) with numerous losses of alleles and the silencing. Finally DPC4 gene appears to be the deletion target in 30% of cases of pancreatic ca, head of familiar shape, with auto function inhibitory mechanism with allelic loss. All three genes are then expression of the cell cycle control system. In the classification of the WHO 80% of pancreatic ductal ca preoperatively diagnosed by fine-needle aspiration cytology with CT-guided In operative diagnosis typing must be final since Codest tumors have the following problems: Differential diagnosis of chronic pancreatitis / adenocarcinoma redefinition prognostic and nosographic Recognition of morphological variants. The purpose of the study is to, through a retrospective analysis of our patients,

MATERIALS AND METHODS

They were evaluated retrospectively 13 patients (8 females, 58-85 years) range with pancreatic cystic neoplasm observed at the Surgery Unit colon rectal from 2007-14 Policlinico Catania, in addition to 11 patients (6 males 5 females range 60- 75 years) from 2008 to 2015 observed at the II clinical Surgical Hospital of Catania .lo study of the tumor was performed with diagnostic imaging, and ECO which allowed a staging local and systemic tumor, which was associated with the use the cytological sampling with eco driven probe that determines the nature of the lesion in 95% of cases foto2 evaluate the indications for treatment of cystic neoplasm of the pancreas.

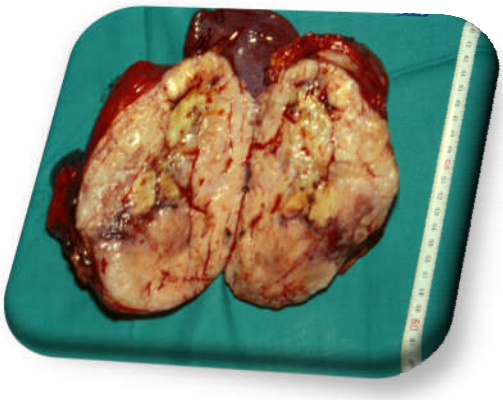

Photo 2 a tumor anatomical

Part 2b TC cyst

An important factor in determining the prognosis is represented by the specificity of the clinical symptoms shown in Table 2

TAB 2 clinical symptoms

Symptomatology based head of the Pancreas seat body tail Weight decreased 82%	100% of patients	
Jaundice	82%	7%
Pain	72%	87%
Anorexia	64%	43%
Nausea	54%	43%
Vomiting	37%	37%
Asthenia	35%	27%
Itching	24%	-

Jaundice was the most frequent symptom, the pain was a negative prognostic factor for the AC body tail. The pancreatic exocrine resulted nonspecific symptoms in the majority of cases. the clinical purpose of a clinical diagnosis of pancreatic ca were characterized by episode of pancreatitis in elderly patients, the appearance of diabetes mellitus in the absence of familiarity and risk factors, and finally the shooting pain in patients with chronic pancreatitis from asymptomatic time the recognition of typical and atypical clinical signs still today represents one of the few medical devices useful for the early detection necessary to improve a prognosis so poor. (16.17) Further research in the early diagnosis have been the genetic analysis of tumors. Codest identified genes and to identify have been used in the early diagnosis in "Hyperplasia" which are one of the first signs of neoplastic transformation. K-ras is a genetic marker present in pancreatic juice (18) but remember its low discriminatory ability in distinguishing low lesions or high cancer risk. Therefore, we are studying the clinical evaluation of more effective molecular tests such as telomerase positive in 95% to ca pancreas. The svilluppo clinical research goes in the direction of providing a gene expression analysis, such that in order to identify correlations with the onset of the AC. the imaging technological evolution has enabled more and faithfully representing the structural characteristics of pancreatic cancers, driving the differential diagnosis between the different histological types of pancreatic study with ultrasound is the first approach if the disease begins with "jaundice" ; the tumor appears as a hypoechoic nodule responsible for a sudden amputation of the common bile duct and / or the Wirsung duct.

In the tail body tumors the neoplasm is uneven for the presence of necrotic foci, the use of color Doppler demonstrates the axis vascular infiltration mesenteric portal. in combination are then facilitate the recognition of MTS liver and the presence of ascites, a typical sign of peritoneal carcinomatosis. Finally with a examination integration through a needle biopsy guided by ultrasound probe it is possible to take cytologic material for diagnosis.

Photo 3 a to TC cystic neoplasm

Photo 3 b endoscopic ultrasound cysts

The imaging thus allow for more accurate diagnosis when it is demonstrated the appearance cystic fot 1 (19,20) Endoscopic ultrasound (EUS) photo 2 helps you therefore to get many important details about the cystic lesions, such as the wall thickness, the presence septa and nodules, also provides for the measurement of the main pancreatic duct, identifying stenosis along their course, and showing the presence of increased lymph nodes. The echo Currency intraductal extension of the tumor in the papilla of water, in cholangiocarcinoma, considering the involvement of the pancreatic capsule (21,22.23) whose absence invasion allows a 3-year survival in 78% of cases, after resection. The method is particularly suitable in the staging tumors of small size can not be assessed by CT (24,25,26) associated with the execution of the FNA to provide a confirmation of the examined mass. The spiral CT study permits through the optimization of contrast radiological displaying peri pancreatic vessels, making it more accurate budget the extension of the tumor. The study pre - contrast graphic, with the exclusion of the presence of calcifications, raises differential diagnosis with chronic pancreatitis. The tumor identification is achieved when maximum contrast is the difference between hyperdense healthy tissue and cancer tissue hypodense, using a thickness of 3mm, making it optimal evaluation of the relationship between cancer and arterial vessels. In the late venous phase are evaluated correctly the neoplastic outbreak relations with the involvement of the superior mesenteric vein (lumen stenosis), the vascular dilation of the pancreatic duodenal artery and gastro - colic (aspect TEAR Drop, stretching of the vessel to the tumor). The venous phase involves the use of the thickness of 5 mm with a possible demonstration of peritoneal carcinomatosis outbreaks or liver MTS (Photo 7-8). The diagnosis is certain when the tumor presents ocular multi aspect and parietal nodules (27,28). The main features of imaging currently adopted for the diagnosis of pancreatic cystic neoplasms include localization, intralesional cysts pattern (unilocular oligo cystic, polycystic appearance), calcifications, communication with the main pancreatic duct or side ducts, thick septa, presence of internal debris or wall nodules. Photo 4 a and b

The possibility of a dynamic study of MRI in contrast graphical phase made MISUSE most competitive method (29,30). In the sequences IF the tumor appears usually ipointensivo and the signal intensity difference between the normal and the tumor parenchyma increase significantly with the administration of the contrast medium, especially if the fat signal is suppressed. The presence of necrosis brings up the unevenness of the outbreak. MRI also allows an accurate tumor extension evaluation.

Photo 4 a to MRI neoplastic cysts

Photo 4 b TC multiple pancreatic cysts

The spread retroperitoneal is characterized by the irregular appearance of the tumor margins and the gradual cancellation of peri-pancreatic fat plane, hyperdense on T1 and T2 weighted sequences, with more accurate assessment of the tumor relationships with peri-pancreatic vessels in different planes space. Finally the study of tree analysis with pancreatic biliary cholangiopancreatography Wirsung MRI technique allows you to get yourself information otherwise available by CT, ERCP and angiography, and attributing to this technique the nickname of "all in one technique". The coexistence of multi eye look with wall and thick septa provided with calcifications makes occurred malignant degeneration highly likely fig 6. in cystic tumors

PHOTO 5 PET cystic neoplasm

After the introduction of a similar radiolabeled "somatostatin" OctreoScan the scintigraphic technique plays a leading role in pancreatic cancer. The resulting survey is functional and visually expresses the drug radio link with the somatostatin receptors. Images can compete in tumor spatial resolution with other methods providing data on the size, location,

heterogeneity of the lesions, specificity in endocrine lesions in the intra operative diagnosis is useful to search for lymph nodes. PET currency is the tissue glycolytic activity in vivo (18f FDG) that the metabolic activity (11c HTP 5) of pancreatic cancers, using the tumor's ability to capture and metabolize the precursors of amines. The metabolic activity of the tumor is correlated to the speed of proliferation, and to the number of proliferating cells; However, this response is also an expression of inflammatory and reparative processes. The advantages of the method "functional" are the obtaining of an image that visually expresses the increase of the metabolic activity of the tissue considered with respect to the surrounding parenchyma. The size, the heterogeneity of the lesions, the MTS <1 cm and positivity expressed in cystic tumors, the malignancy of the lesion, confirming the leading role assumed by the method in recent years. Photo 6 a, b and c

Photo 6 cyst pancreas

photo 6 b TC cysts head of the pancreas

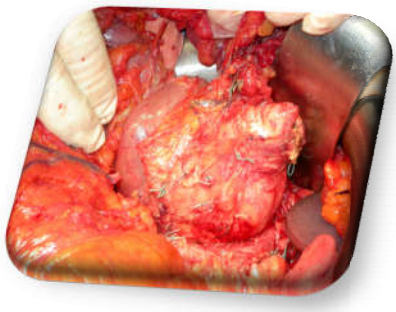

photo 6 C anatomical part

and evaluation of the diffusion in the peritoneum back has provided important information to the criteria. Resectability Il CEA and CA performed on the cystic fluid withdrawn with ultrasound probe has confirmed the validity of the performance of the method with the values obtained, which influenced the choice of treatment. The statistical incidence of chronic pancreatitis was 22% of cases observed in patients, the TNM staging of cancer in Group I in n 5 cases were in T2MoNo stage, in 7 cases in stage T3 M1NX.Nel II Group No. 9 cases T3MXNX stage and the remaining cases T4MXNX.

RESULTS

In reference to the first group of 13 patients with pancreatic cystic neoplasm. In this group in each patient, it was adopted a different clinical approach based on different criteria: age, comorbidity, imaging characteristics, symptoms, life expectancy. After joint evaluation with various specialists (oncologist, radiation oncologist, surgeon) In 8 cases, the resection surgical treatment was chosen, while in the remaining 5 cases has been preferred a more conservative approach. Treatment was performed in N 4 cases, a DPC, in n2 cases a body tail resection, in one case the total pancreatectomy. In group II consisting of 11 patients, was adopted a more aggressive clinical approach based on diversified resectability criteria were: the absence of mesenteric portal axle invasion, and the absence of MTS documented both the echo that the CT. With this criteria in 4 cases was performed curative resection surgery, in the remaining seven cases although mind the criteria of unresectable, which contrasted with the good clinical conditions, and ASA modest, Ia clinical condition of the patients was key to orienting treatment in resective and palliative.Il treatment performed and a DPC was therefore 7 cases of n and n 4 in a body tail resection. In patients who have had surgery resection the incidence analysis data of the complications of the different treatments performed are as follows. And illustrated in Table 3

TAB 3 Incidence of complications

The Group I

A. operative mortality for interventions resectional was performed in the 0% The average stay 35-40gg

   a. The operative mortality for derivative and explorable interventions and it was nothing
   b. N 2 stent applied endoscopic or percutaneous
   c. stenosis gastrodigiunali dilation and anastomosis after 3 months in 0.9% of cases

In group II

A. operative mortality for resective procedures performed was of 20. The average hospital stay 50% -60gg in line with the national average
B. The operative mortality for derivative and explorable interventions and was nothing
C. N 7 stent applied endoscopic or percutaneous
D. stenosis gastrodigiunali absent
E. pancreatic fistulas 30%

The data presented indicate an increased incidence of complications, and mortality in the group of patients whose criteria of unresectable contrasted with the good clinical conditions and low ASA, and with the greatest percentage of applied stent. The pathological examinations of operated cases are illustrated in TAb 4

Tab 4 histologies

The Group I

N 3 cases; serous cystadenoma, 3 of which had an average of between 6-11 cm in diameter in the cephalic mechanically obstructing the bile duct

N 6 cases of mucinous cystadenoma which n 2 with chronic pancreatitis with 2 cm diameter cyst,

N 4 cystadenomas small serous cysts which n 4 peripherally calcified considered pathognomonic sign of malignancy in association with a case of a right colectomy histologically confirmed

Group II

N2 cases cyst adenomas mucinous , No. 1 in A clear cells, n 1cases to oxyphil cells, the average diameter of the cysts 5-7 cm, all in the cephalic.

N2 cases cystadenomas sarcomatous with chronic pancreatitis with cysts that ranged 3-4cm in diameter, all in the cephalic.
N1caso cystadenomas squamous, with cysts that ranged 2-5 cm in diameter, calcified peripherally in the cephalic, and mechanical obstruction of the common bile duct with dilation> 7cm

N 4 cystadenomas serous cases with cysts 2.-5 cm in diameter, the seat body tail, mechanical obstruction of the common bile duct and dilatation> 10 cm

Examinations of histologies confirm the increased incidence of cases of cystic lesions and undergoing treatment, in addition to increased morphological differentiation in the second group of patients, due to the refinement diagnostic. The conservative management criteria implemented only by the group of patients is shown in Table 5

TAB 5 the criteria of conservative treatment

over70
lesions <3 cm,
headquarters pancreatic back

absence of symptoms with occasional radiological findings
in Table 6 also illustrates the resection of the criteria of the two treatment groups

TAB 6 of pancreatic resection criteria

The Group I

Small asymptomatic lesions> 4 cm

High index of CEA

Biopsy of the cyst fluid with positive EUS for tumor

mechanical obstruction of the common bile duct with dilation> 6 cm

Diabetes

Group II

Small cystic lesions> 4 cm

High index of CEA

mechanical obstruction of the common bile duct with dilation> 6 cm

Partial stenosis by compressing the duodenum
The variations in the two groups are due to less selective surgical criteria in the II group of patients, with a diagnostic imaging that had placed a fair evaluation of patients, such as not to leave different margins of interpretation.

DISCUSSION

Surgery is currently the only treatment with curative intent, despite the claims of Gudioronsson, Di Catalto and others on the need and usefulness of a Intervet resection Codest treatment remains the gold standard for the treatment of pancreatic ca. in the therapeutic indications the role of laparoscopy has been evaluated in recent years and for some directions is encoded the ability to perform derivative and resective interventions. Ca in the pancreas despite the accurate preoperative staging, the current remains the impossibility of identifying the peritoneal carcinomatosis and liver lesions <1 cm often only diagnosed at laparotomy that when present exclude the resection therapy. The mere introduction into the abdomen of a laparoscopic optic significantly reduces the rate of unnecessary exploratory laparotomy for the exclusive benefit of the patient. laparoscopic evaluation of the resectability of the tumor can be very accurate with the ability to access the back side of the cavity Epiplon using the way sopragastrica., and the diagnostic study involves the use of laparoscopic ultrasound probes which allow to evaluate the infiltration of vascular structures lymph nodes and biopsies. In palliative carcinomas unresectable the realization of digestive and biliary laparoscopic are: a) Gastro enteric anastomosis forward colon iso peristaltic, lateral chest whose execution is easy b) the hepatic jejunostomy whose packaging remains burdened by significant difficulties of implementation. c) The laparoscopic biliary palliation is then reserved in those cases in which the positioning of the endoscopic stent is not possible. D) in the pseudocyst whose nature is confirmed by the wall biopsies can be performed cistus fasting anastomosis lateral-lateral by mesocolic Roux. Respecting the same surgical time of the open technique. Procedures in resettive laparoscopic enucleation of the endocrine tumors is feasible only when the lesion is benign, localized on the anterior surface of the gland. The use of ultrasound to ease the dissector surgical procedure. It reduces the risk of bleeding. The distal Pancreatectomy. It is workable; for benign lesion or low malignancy localized body queue boundless from the pancreas This surgical procedure is then to be a candidate to become the gold standard due to Magnificent vision and perfect anatomical definition. the preservation of splenic vessels is then easier with this method .the major surgery are not considered yet codified procedures. The laparoscopic technique with proper training is a useful tool in pancreatic surgery and rightfully enters in the diagnostic operation. (29,30,31,32). The current standard of surgical treatment of pancreatic cystic tumors were defined by the consensus conference .The criteria of a standard DCP are shown in Tab7

Tab 7 criteria of resectability of DPC

a. of the pancreas section isthmus level, at least 1 cm from the tumor
b. the margin of pancreatic section must be negative extemporaneous histological examination.
c. the conservation of the pylorus is shown, with the exception of those cases in which the location of the tumor is located in the dorsal portion of the head.
d. vascular resection (or adjacent organs) and allowed for the purpose of obtaining free margins.

e. Regional lymphadenectomy. Pancreatic duodenal front and rear, right A. Mesenteric, and hepatoduodenal ligament, the anterior region A common hepatic
f. Package pancreato duodenal anastomosis to follow on the same loop
g. anastomosis biliary digestive duodenum and jejunum.
h. Mortality <5%
i. Meticulous surgical technique to reduce perioperative transfusion.urgery and open new frontiers

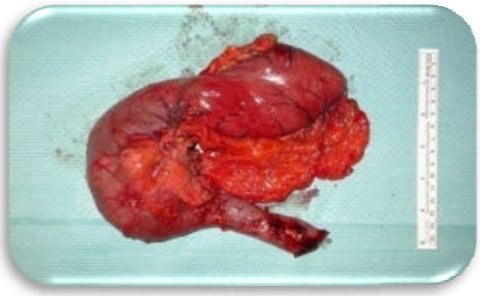

Photo 7a DPC

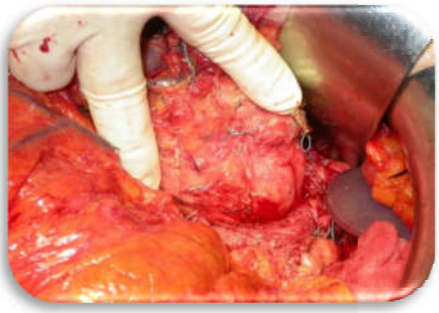

Photo 7 c Anatomical tumor

The criteria of reducing complications. It is illustrated in Table 8

Tab 8 for reducing complications criteria

- Centralization consists in referring patients candidates for surgery of pancreatic surgery in a few specialist centers to ensure adequate standards of treatment (meticulous surgical technique, management and frequent serious complications in the post-operative).(33,34,35)
- Prophylaxis with Octreodite for reduction of complications () controversial data.
- Immunonutrition NPT able to modulate the immune and inflammatory response.

The treatment of pancreatic stump Postoperative pancreatic fistula has an incidence between 5-15% and is correlated to a mortality of 20%. currently performs the following anastomosis:

A) Pancreatic jejunostomy
B) Pancreatic gastrostomy with occlusion of the pancreatic duct with neoprene in the presence of diabetes.
The latter in a comparative randomized study argues in favor Of this surgical technique .The fistulas after occlusion of the duct are not activated and therefore is little risk of anastomotic leakage (36,37,38)

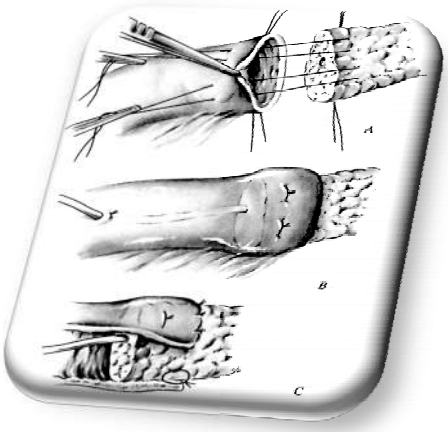

Photo 8 to rebuild

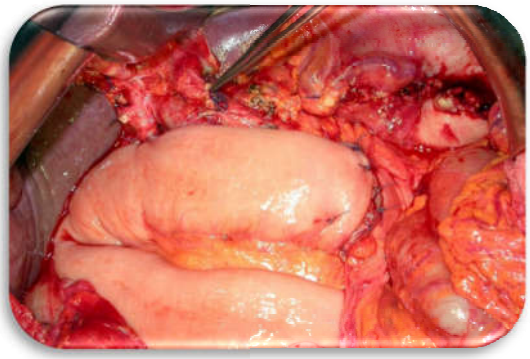

Photo 8 b anastomosis performed.

Improved survival

The improvement of the oncological results in terms of long-term survival regarding the surgical side (greater extent of resection). extended lymphadenectomy has seen in recent years more attention but the results are controversial. (39,40,41)

Vascular resection

A critical aspect of an extended surgery involves implementation of a resection in the presence of infiltration of peripancreatic vessels whose distance results are disappointing so as to advance the hypothesis of a pallia advanced action.

Radio chemotherapy

Preoperative appears to provide results in advanced AC with an increase in median survival of 19 months. In the adjuvant instead you can not prove the role of efficacy of this treatment option. By contrast in the IORT not show a significant difference for which it was shown that its usefulness is limited in the presence of disease, and in the initial stage exists then an integrated therapeutic space to obtain discrete distance results

Resectability

Resectability in relation to the various authors ranged from 9% to 57% (34). The criteria are not always adequately defined or considered .A review of the AA literature they are in agreement and indicate:

A. the placement of a stent in the bile duct in potentially resectable patients.

B. The post-operative biliary drainage should be avoided in patients who are candidates to the DPC. In Table 9 discusses the resectability criteria in AC pancreas.

TAB 9 Criteria for unresectable

a. Liver Mts with axis-portal or mesenteric infiltration of large artery peripancreatic vessels (celiac artery, hepatic artery, Mesenterica artery sup.)
b. If cytology of ascites confirms the presence of cancer cells.
c. The laparoscopic diagnostic test documents MTS liver / and or peritoneal
d. In a foul Karnosky Index, ASA 5, age, associated diseases.
e. Fix the surgeon to perform the isolation and liberation of adhesions in the trunk mesenteric portal detectable by CT, and Angio RM.

In Table 10 shows the: surgical resection criteria palliative

Tab10 criteria for surgical resection palliative

a. Good general condition
b. Neoplasms body tail with MTS liver
c. DPC in centers with high n interventions / year.
d. General Surgery Centers with N / appropriate interventions

Surgery in open versus laparoscopic surgery The retrospective comparative studies show the equivalence of the technical expertise of the endoscopic or surgical team. Pallazione endoscopic

The problems that you are called to solve are the 'Jaundice secondary to compression and / or neoplastic infiltration of the bile duct and duodenal stenosis. indications are illustrated in Table 11:

TAB 11 indications to the Palliative Treatment

a. The endoscopic drainage is preferred to trans liver
b. It is not required a complete sphincterotomy as it reduces complications%
c. Endoprosthesis replacement every 6 months
d. Chronic Pain
e. Intraluminal brachytherapy
f. Pancreatic Infection
g. Duodenal stenosis affixing self expandable metallic endoprosthesis in neoplastic obstruction of the duodenum

Pain treatment

One of the most frequent symptoms of pancreatic ca, and certainly the most temibile.Un unlenited pain has an effect on all the activities of paziente.I periods without pain are related to a lower incidence of mood disorders on (.42,43) maintained pain via sympathetic is less prevalent than nociceptive or immediate neuropatico.Un sympathetic blockade and physical therapy are shown in Table 12

TAB 12 neurolysis

a. The Splancnicectomia Intraoperative

It requires one of the largest bilateral resection and small splanchnic at their entrance into the abdomen

B The chemical Splancnicectomia percutaneous injection20ml of 50% alcohol 50% sol Physiological

a. Radiotherapy Convectional
b. Chemotherapy with gentamicin
c. Therapy with fans and / or based analgesics.

The Patients have no uniformity for each picture of the stage of disease. The pain has a direct correlation with increased survival (44,45) inducing a depression reduction, and improved mobilization, socialization, life expectancy with the 'Food intake.(46,47,48,49,50)

CONCLUSIONS

In recent years the scintigraphic techniques at immaging regard diagnostics and stanging of pancreatic tumors have been innovative and have gained a role of primary importance. EUS seems to be the most reliable technique in the staging (T) regional site and lympho node (N), and also shows its high reliability (95-100%) to obtain tissue samples with needle biopsy EUS FNA under direct vision with suction ultrasound of cytological material it makes superfluous' use of other diagnostic study surveys and influencing our clinical decisions in 68% of cases. The laparoscopy surgery is a useful tool not only diagnosis but also in operating selected cases, with the benefit of avoiding unnecessary laparotomy in cases of inoperable cancer pathologist, and with the opportunity to perform derivative and resective procedures in the presence of an acquisition and experience of 'operational diagnostic algorithm. The treatment of unresectable AC is considered affordable for any surgical ward but remains high and significant morbidity and operative mortality. For the purpose of ensuring a lower risk you must have the appropriate experience, in addition to the possibility of applying alternative methods to those surgical. Current standand of the pancreas AC treatment are given specific parameters represented by the headquarters the size of staging lymphadenectomy, a mortality rate of 2%, with a meticulous surgery, and the centralization of seats to obtain an N / Annual appropriate interventions, with 2% of complications, and a survival rate to 58% at 5 years. The best results of the treatment of pain resulting from a careful evaluation of it analysis. Mutational of neoplasms in the presence of "hyperplasia" represent one of the first signs of neoplastic progression, for which the use of mutation testing in the pancreatic juice are a promising identifying patients with incipient neoplastic disease. The analysis of the size of the pancreatic cancers problem indicates how the pancreas become an organ in which it can operate, anatomical and pathological classifications are more refined with new pathological forms. In clinical practice, there has been an increase in cystic endocrine neoplastic, and The contribution of molecular biology to put direct to the understanding of early diagnosis of neoplastic transformation mechanism., Identified markers for diagnosis and prognosis. Research and studies have introduced the concept "Clinical Benefit" therapeutic strategies with a view "to care". The healing that involves a minority of patients is a project that goes in the direction of an adjusted budget cost / benefit in terms of quality of life.

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