

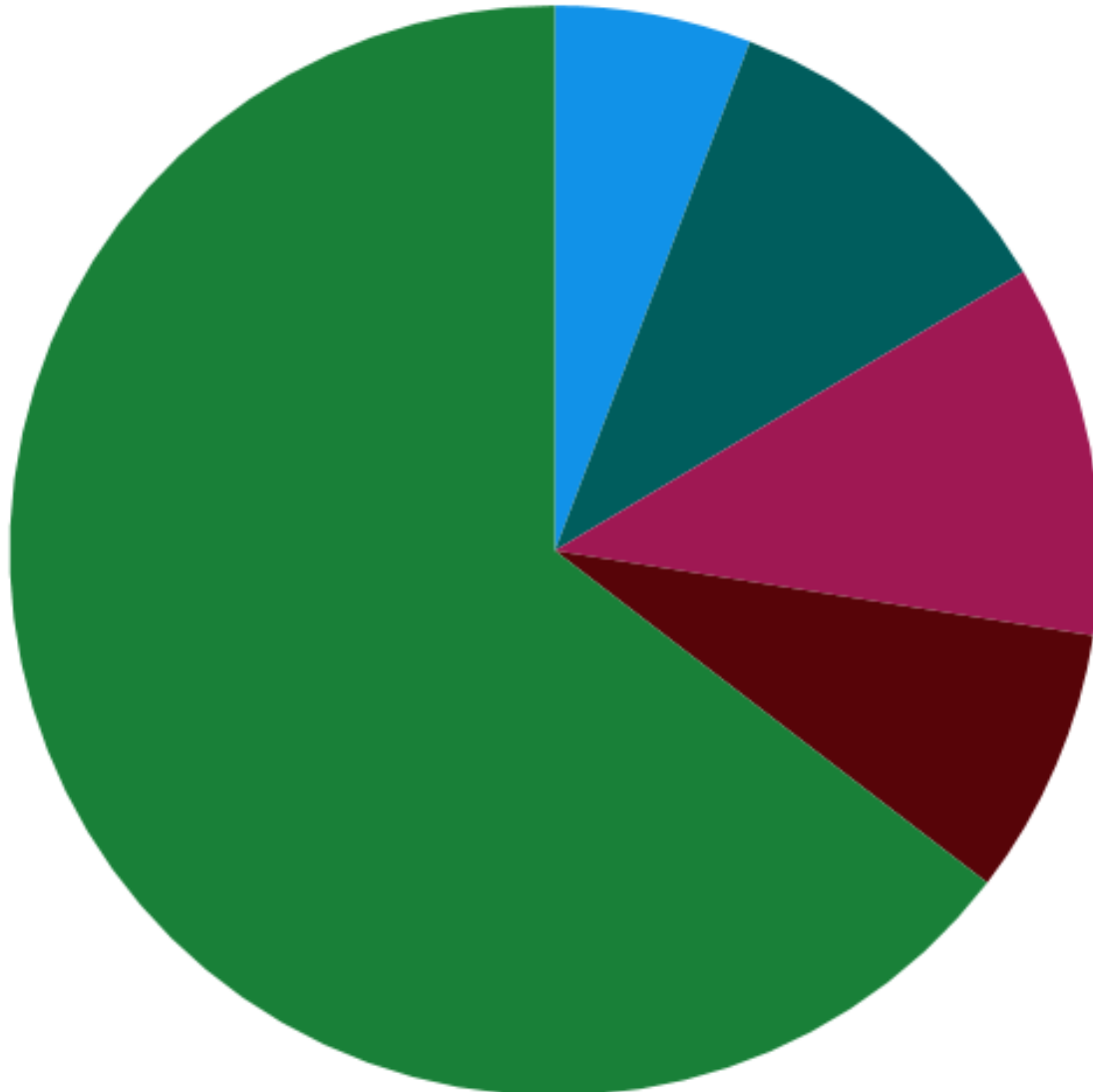
Pankreaskarzinom: Highlights für die Versorgung

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Klinik für Chirurgie, UKSH Campus Lübeck

26. Netzwerktagung für Qualität und Versorgung in der Onkologie 2025

10. Bundesweite Onkologische Qualitätskonferenz 2024

Überblick – Entitäten



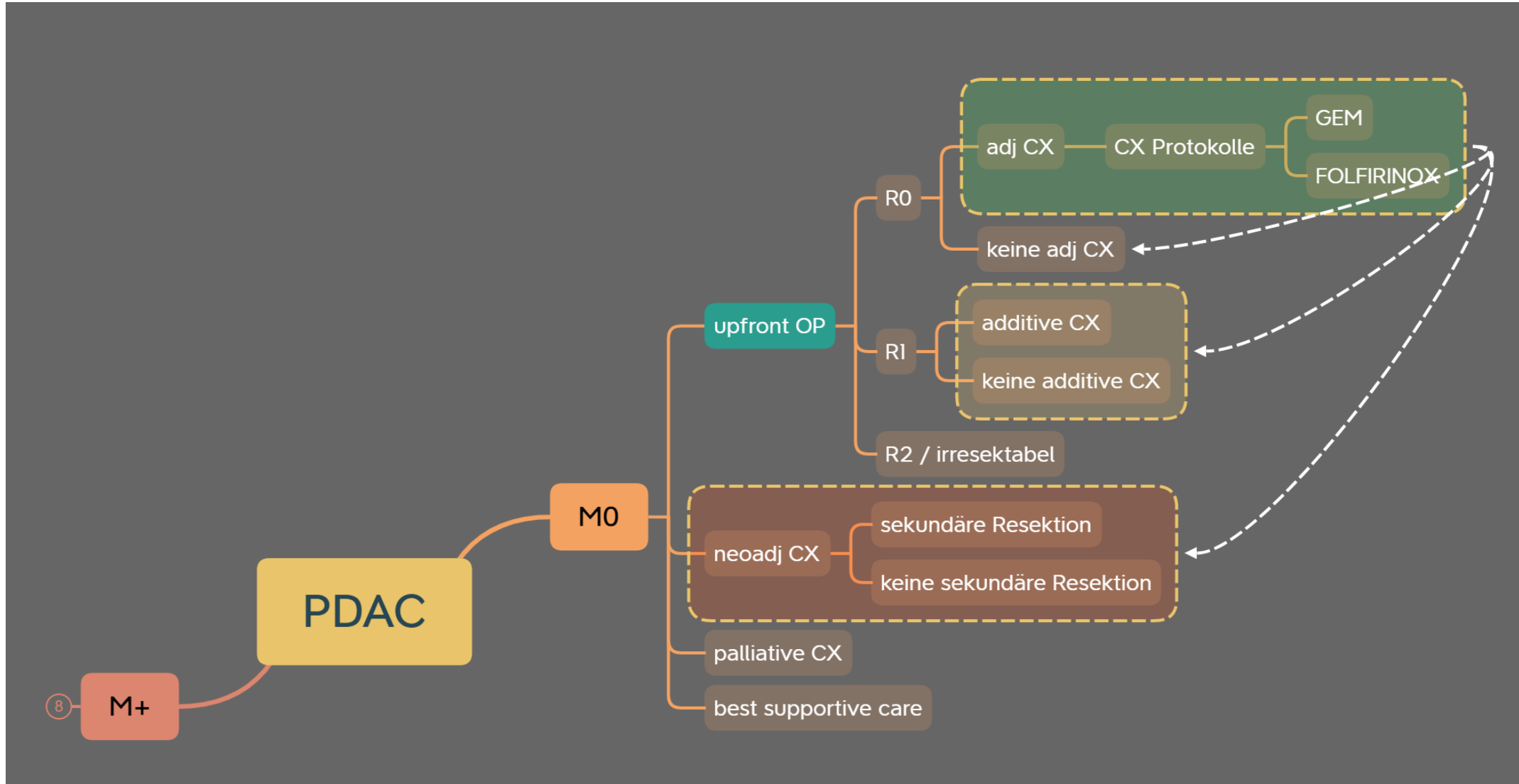
Entities of periampullary carcinomas

- Amullary carcinoma
- Distal bile duct cancer
- Gall bladder cancer
- Duodenal adenocarcinoma
- Intrahepatic bile duct cancer
- Pancreatic ductal adenocarcinoma

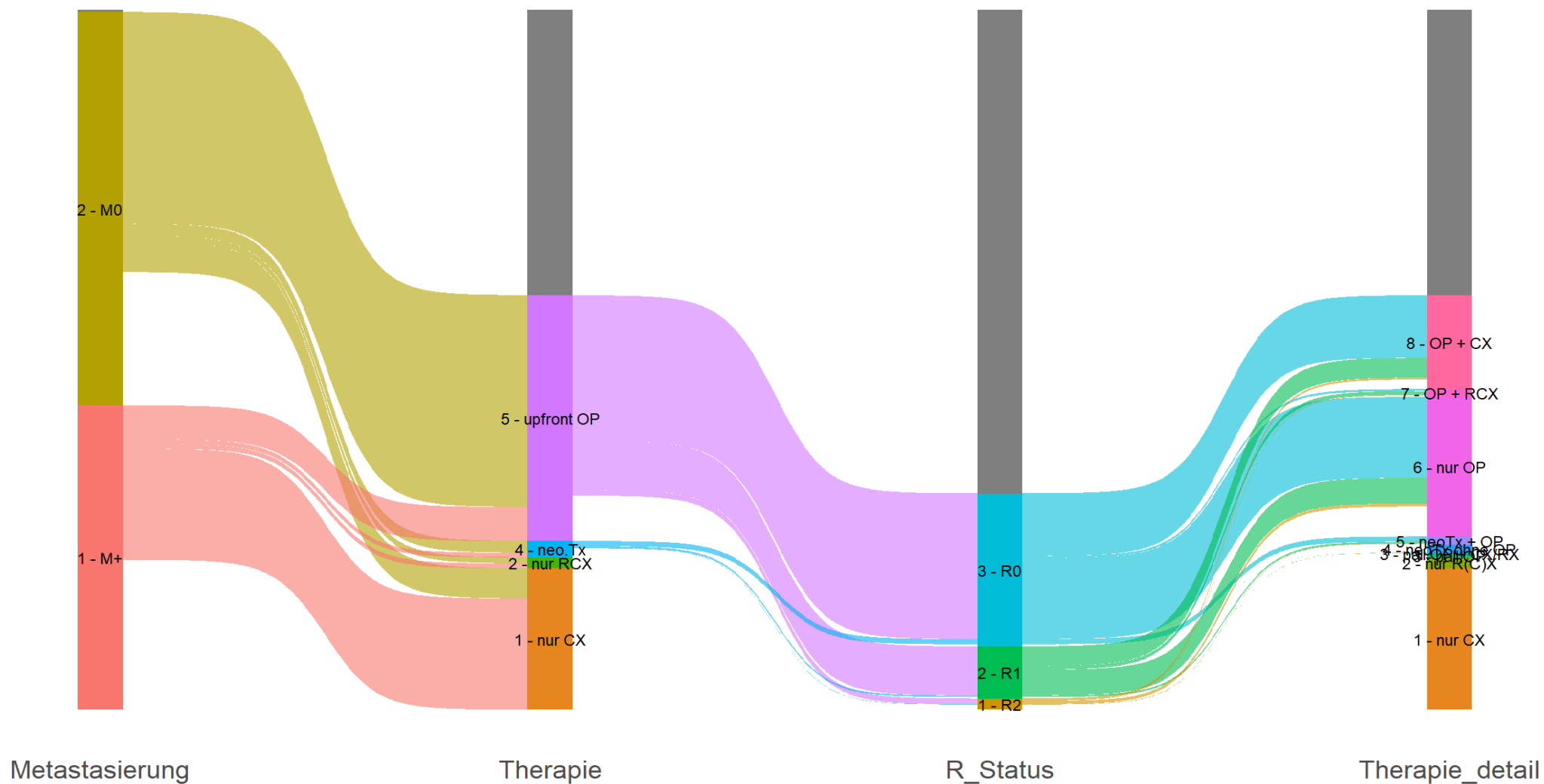
Fallzahlen

Ampulla Vateri:	7 k
Distaler Gallengang:	16 k
Gallenblase:	13 k
Intrahepatische Gallengänge:	10 k
Pankreas:	100 k
Andere seltene Entitäten:	1 k

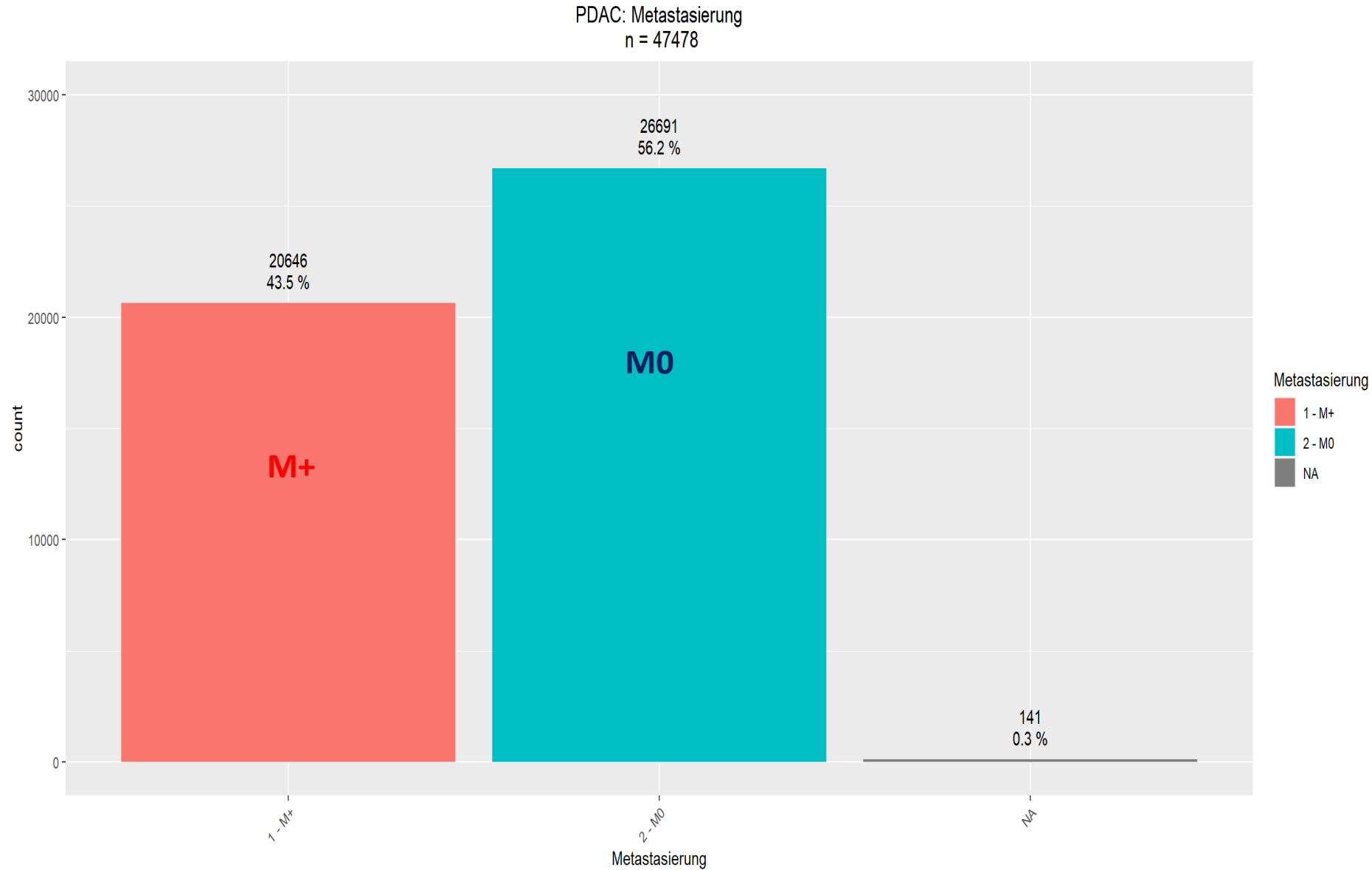
Pankreaskarzinom : Therapieschemata



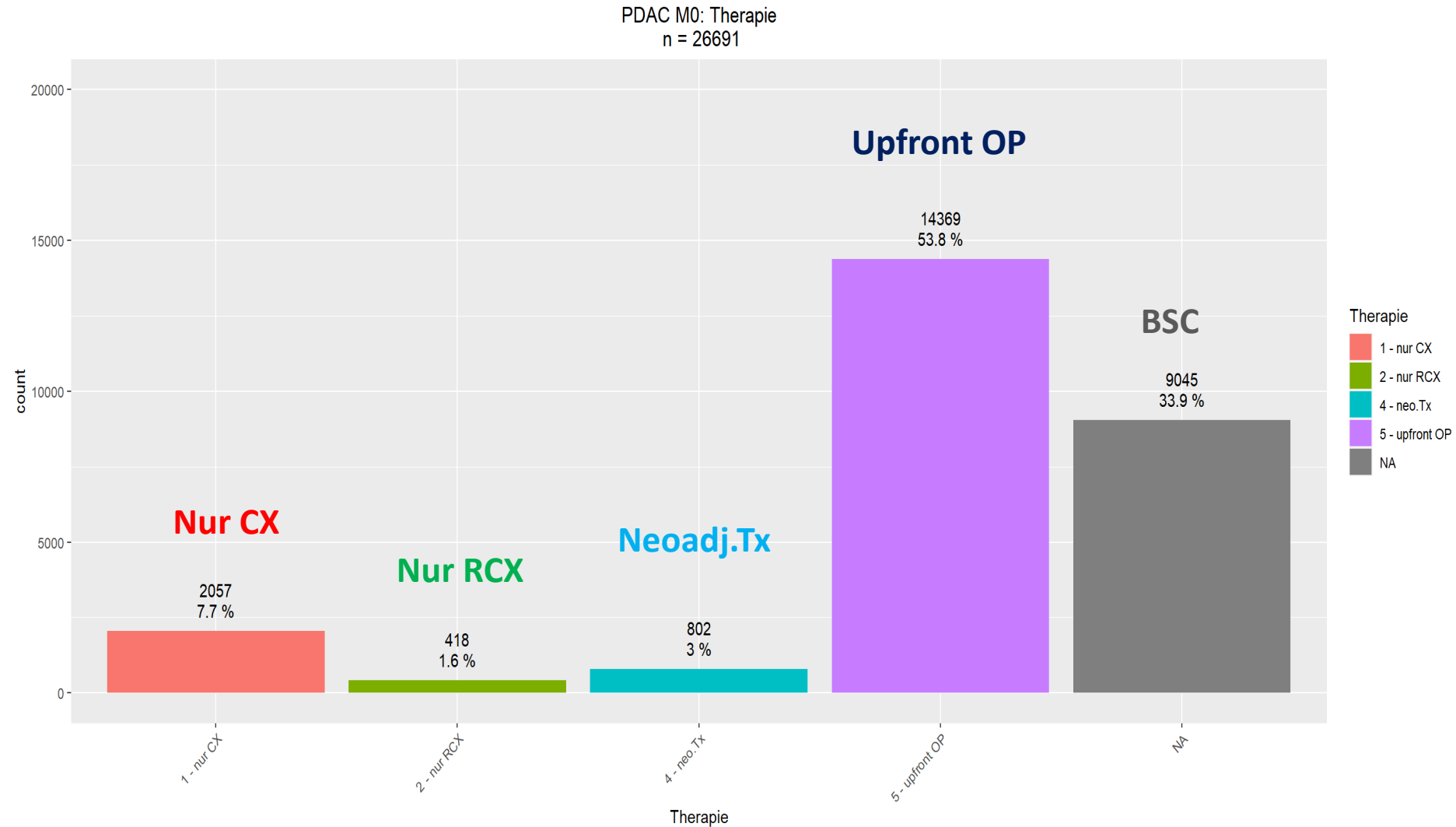
PankreasCA : Therapieschemata



PDAC: primäre Metastasierung

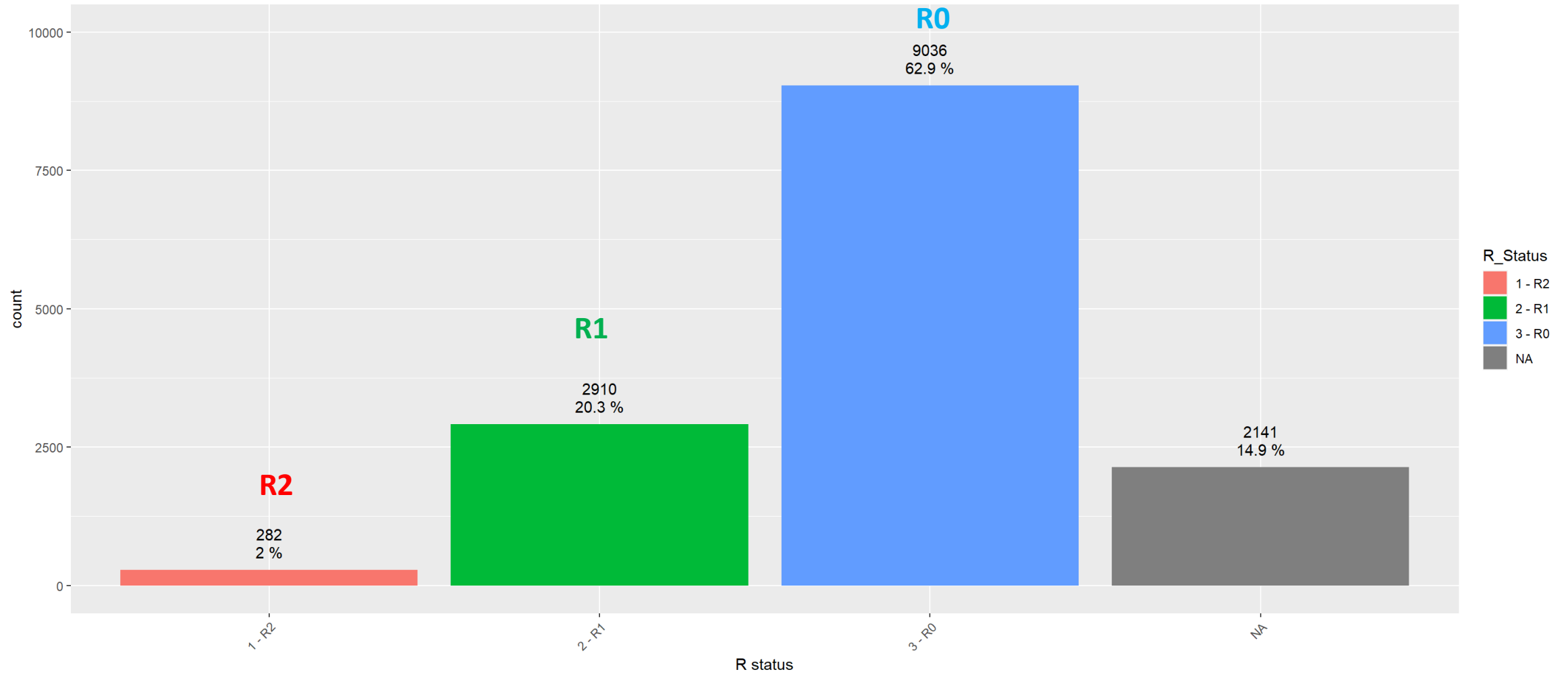


PDAC M0: Therapie



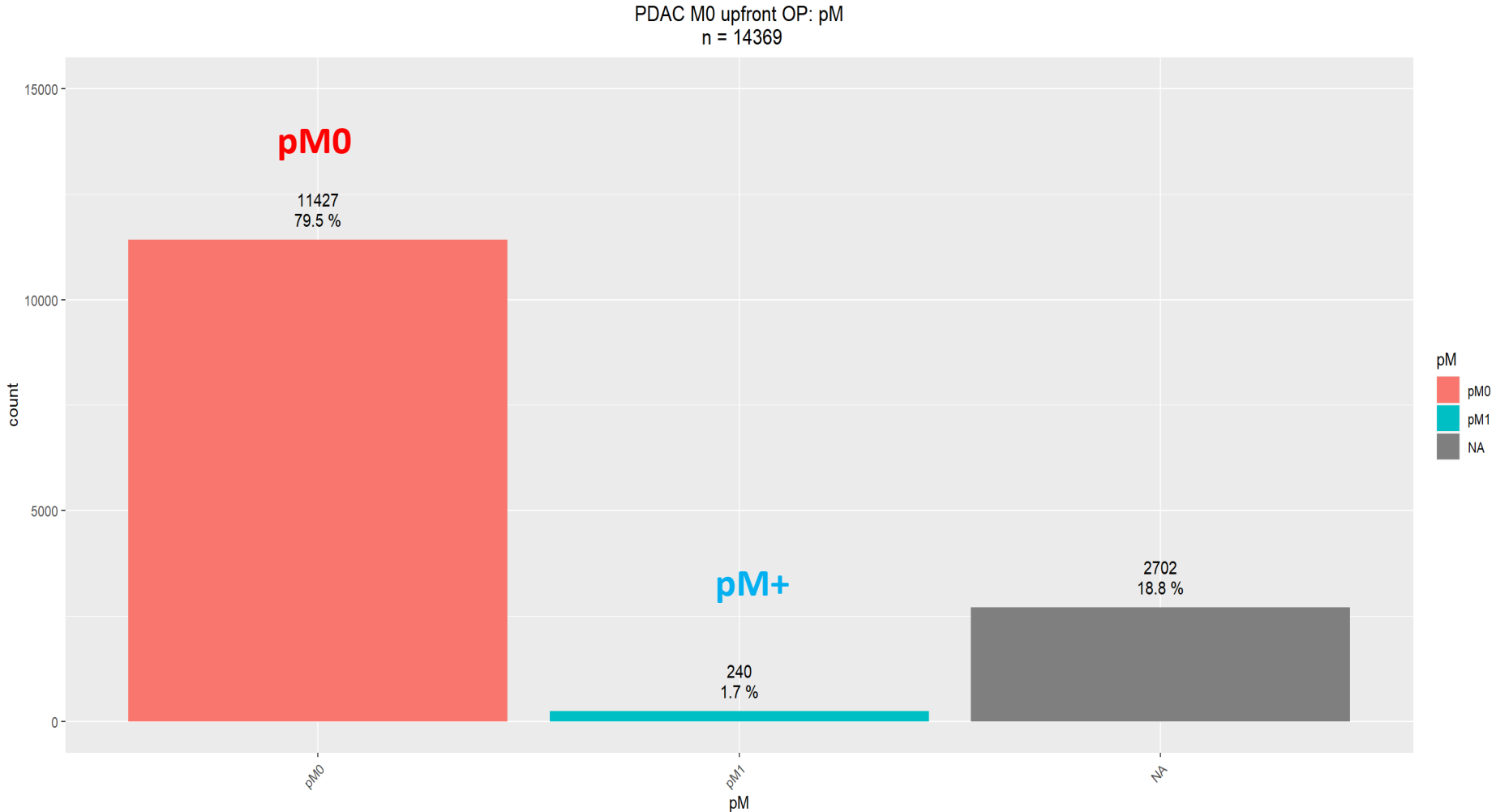
PDAC M0 upfront OP: R-Status

PDAC M0 upfront OP: R
n = 14369

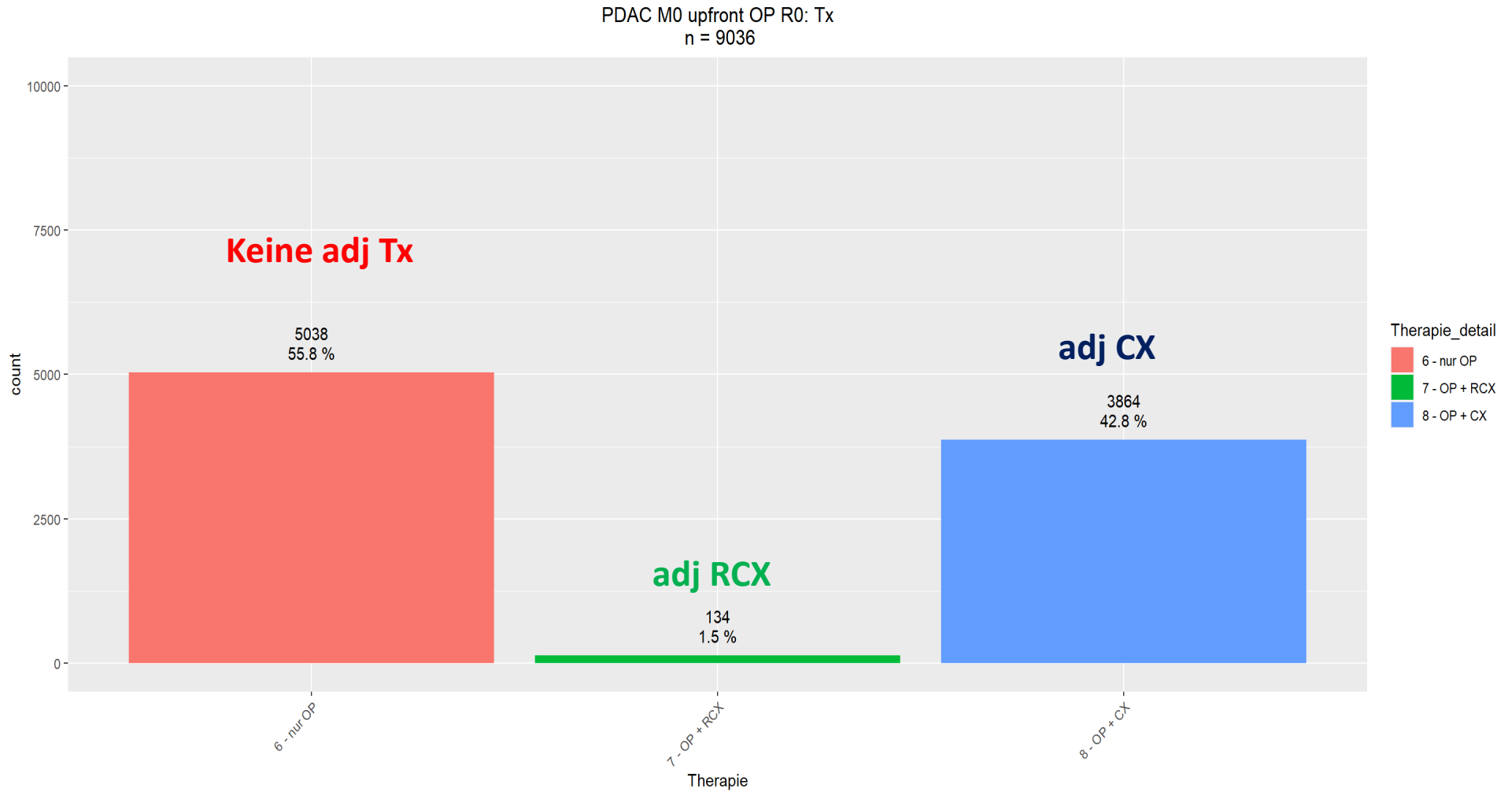


R_Status
1 - R2
2 - R1
3 - R0
NA

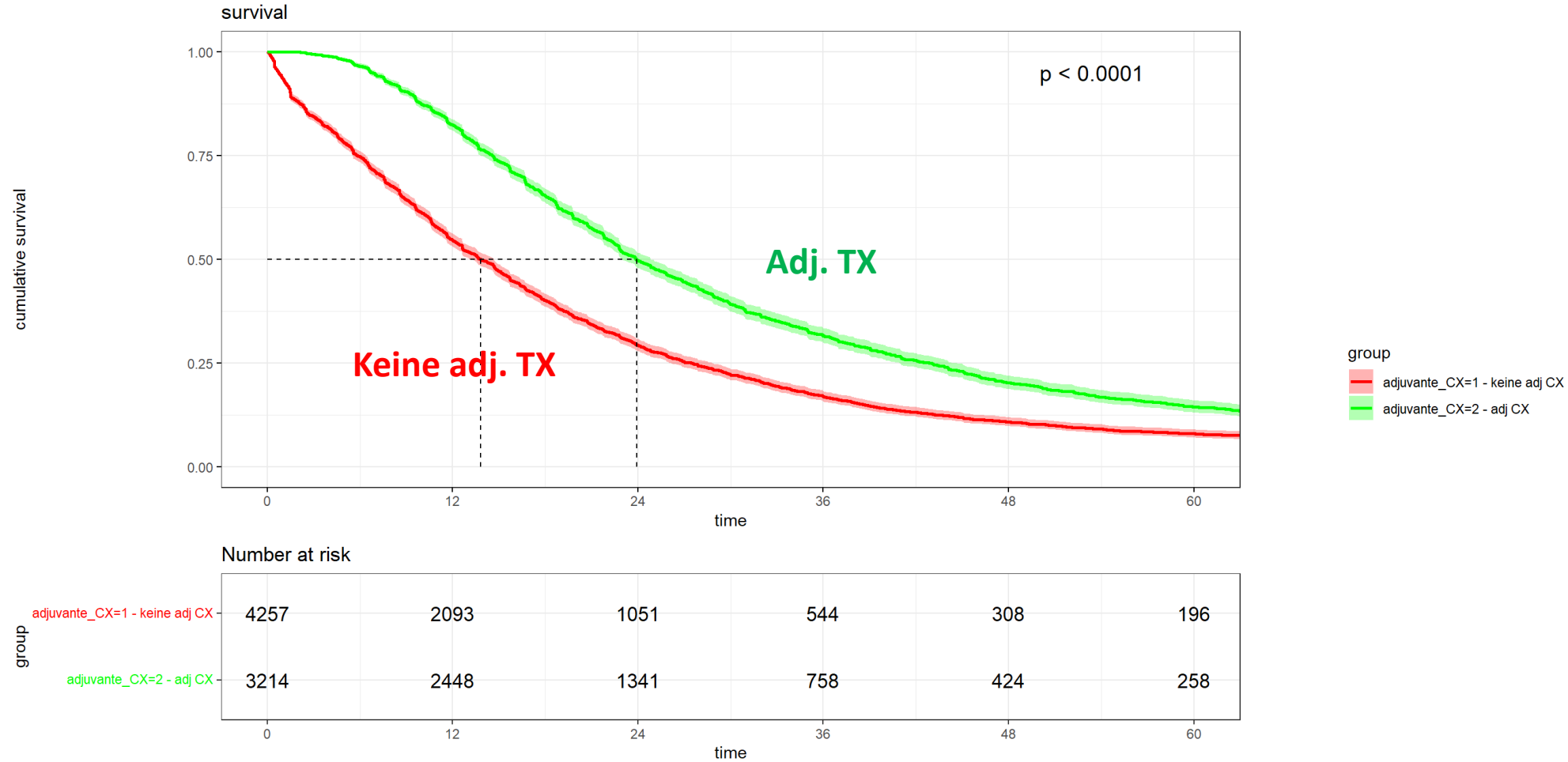
PDAC cM0 Resektion: pM



PDAC M0 upfront R0: adj. Therapie

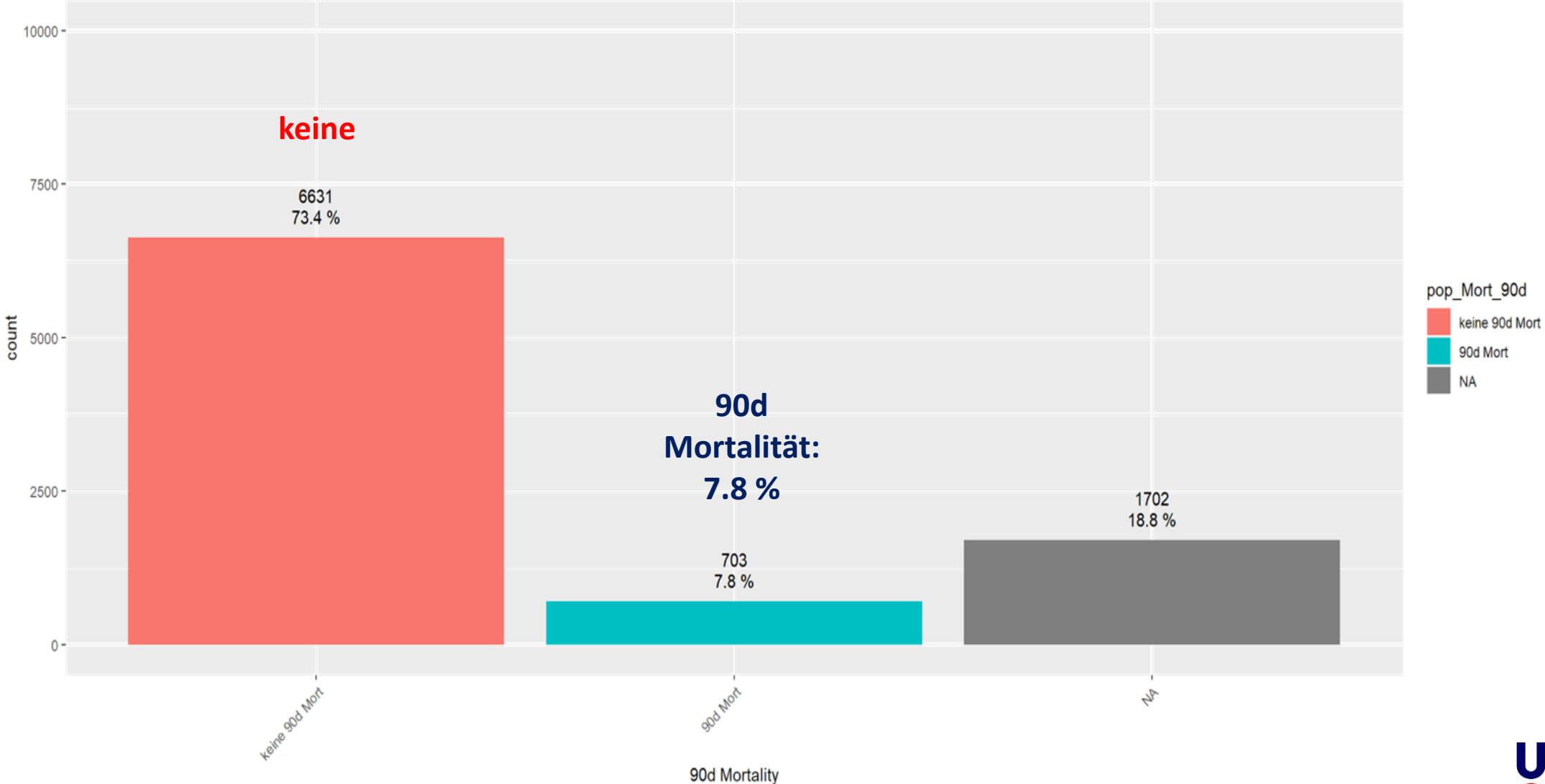


PDAC M0 upfront R0: adjuvante Therapie

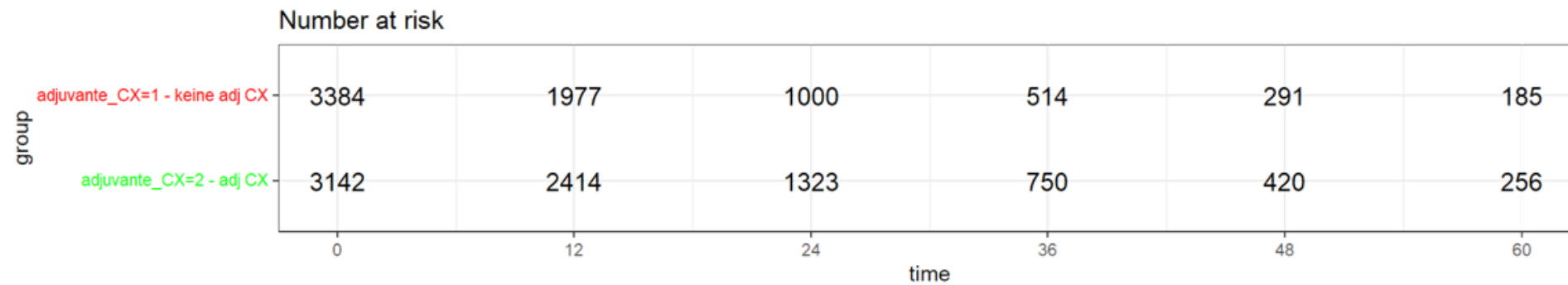
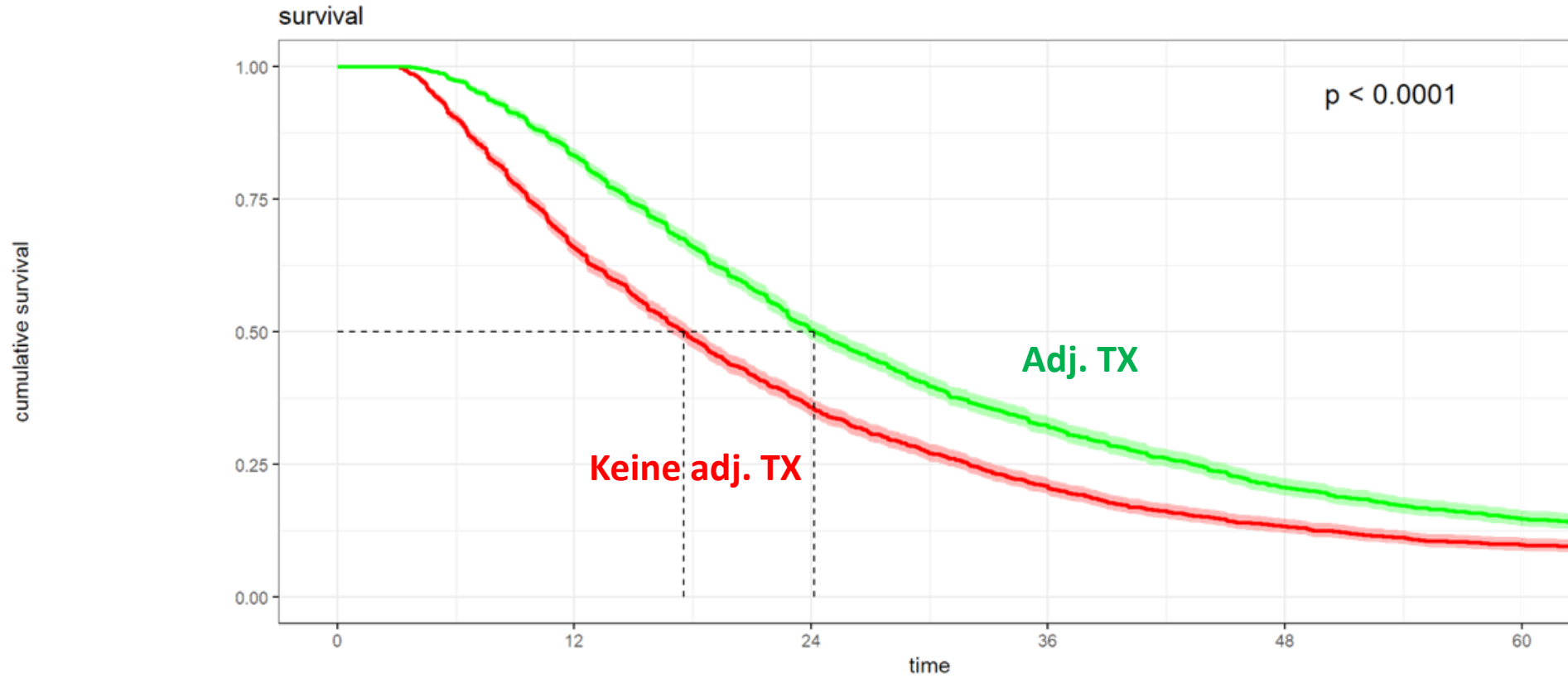


PDAC M0 upfront OP R0: 90d Mortalität

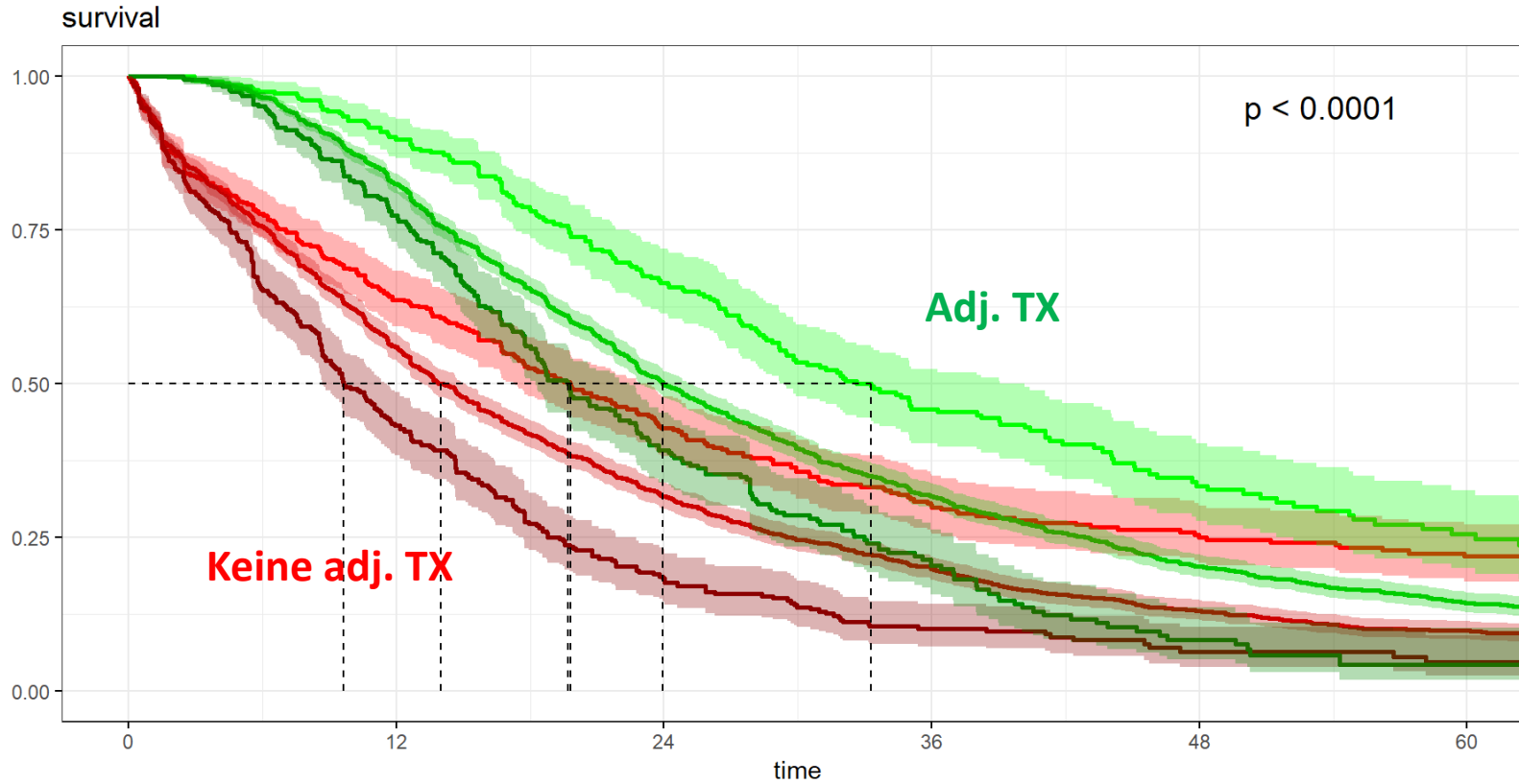
PDAC M0 upfront OP R0: 90d Mortality
n = 9036



PDAC M0 upfront OP R0: Tx ohne 90d Mortalität



PDAC M0 upfront R0: adjuvante Therapie



group

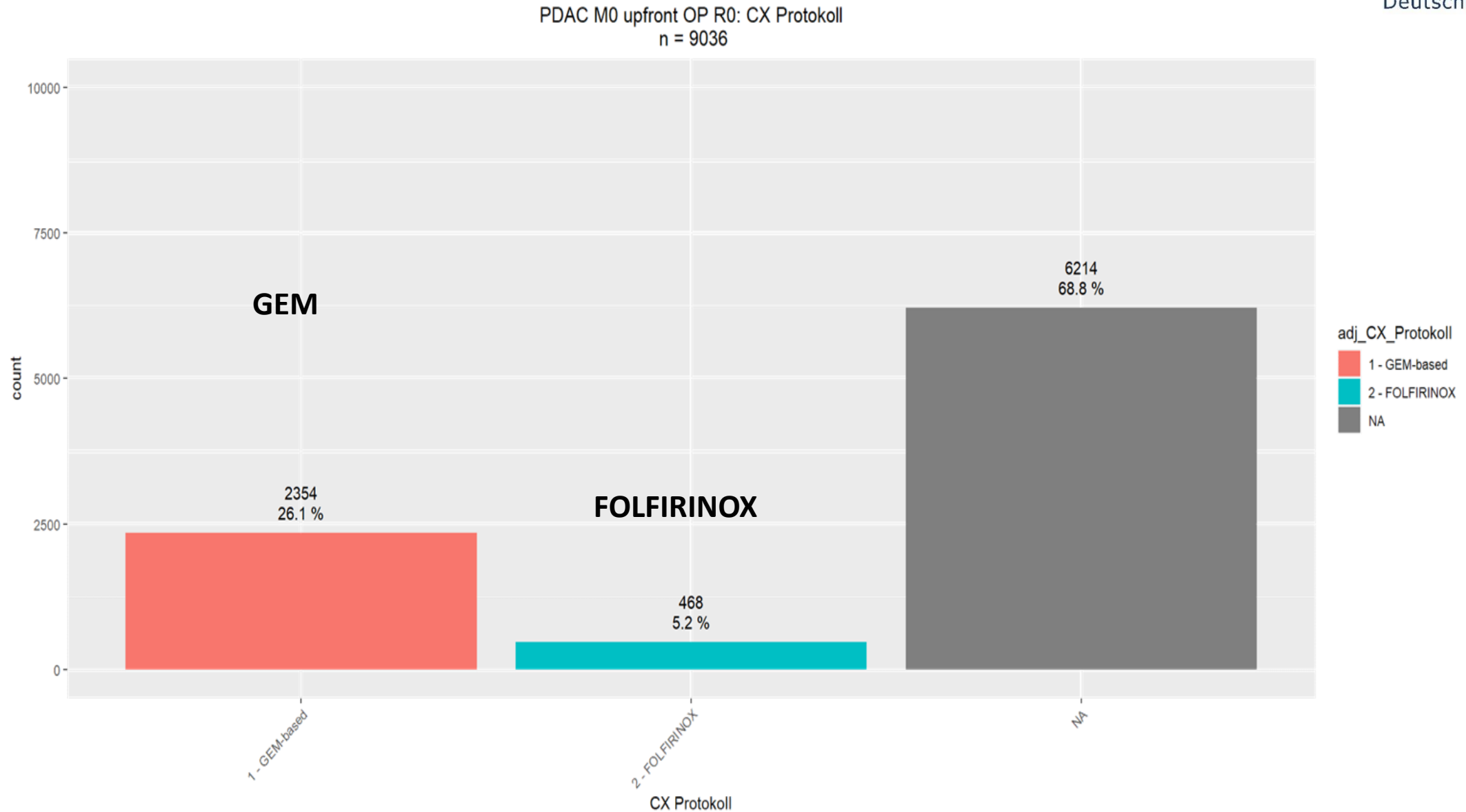
- stage_adj=1 - keine adj CX stage I
- stage_adj=1 - keine adj CX stage II
- stage_adj=1 - keine adj CX stage III
- stage_adj=2 - adj CX stage I
- stage_adj=2 - adj CX stage II
- stage_adj=2 - adj CX stage III

Number at risk

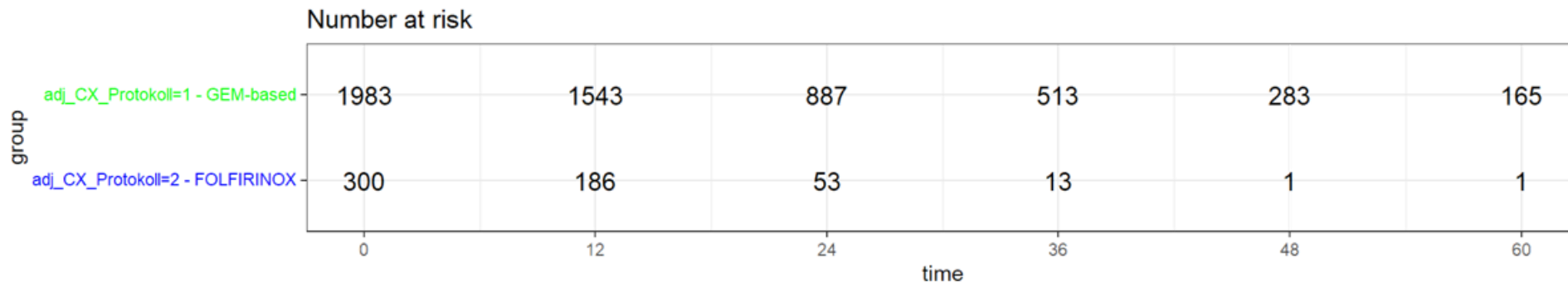
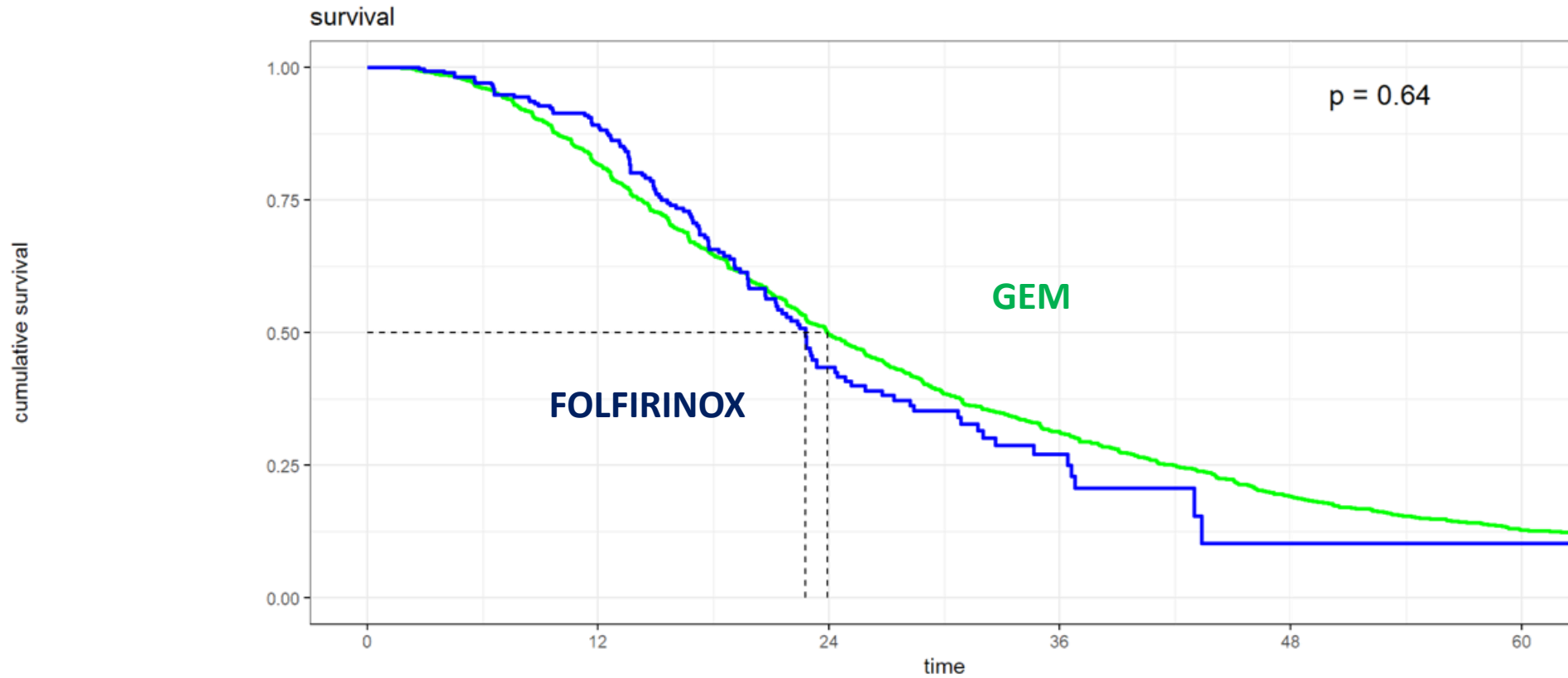
group	0	12	24	36	48	60
stage_adj=1 - keine adj CX stage I	511	261	155	89	62	49
stage_adj=1 - keine adj CX stage II	2040	1053	565	327	198	127
stage_adj=1 - keine adj CX stage III	416	149	57	27	9	6
stage_adj=2 - adj CX stage I	381	290	180	96	51	32
stage_adj=2 - adj CX stage II	2257	1764	1000	591	344	211
stage_adj=2 - adj CX stage III	358	242	94	37	11	3



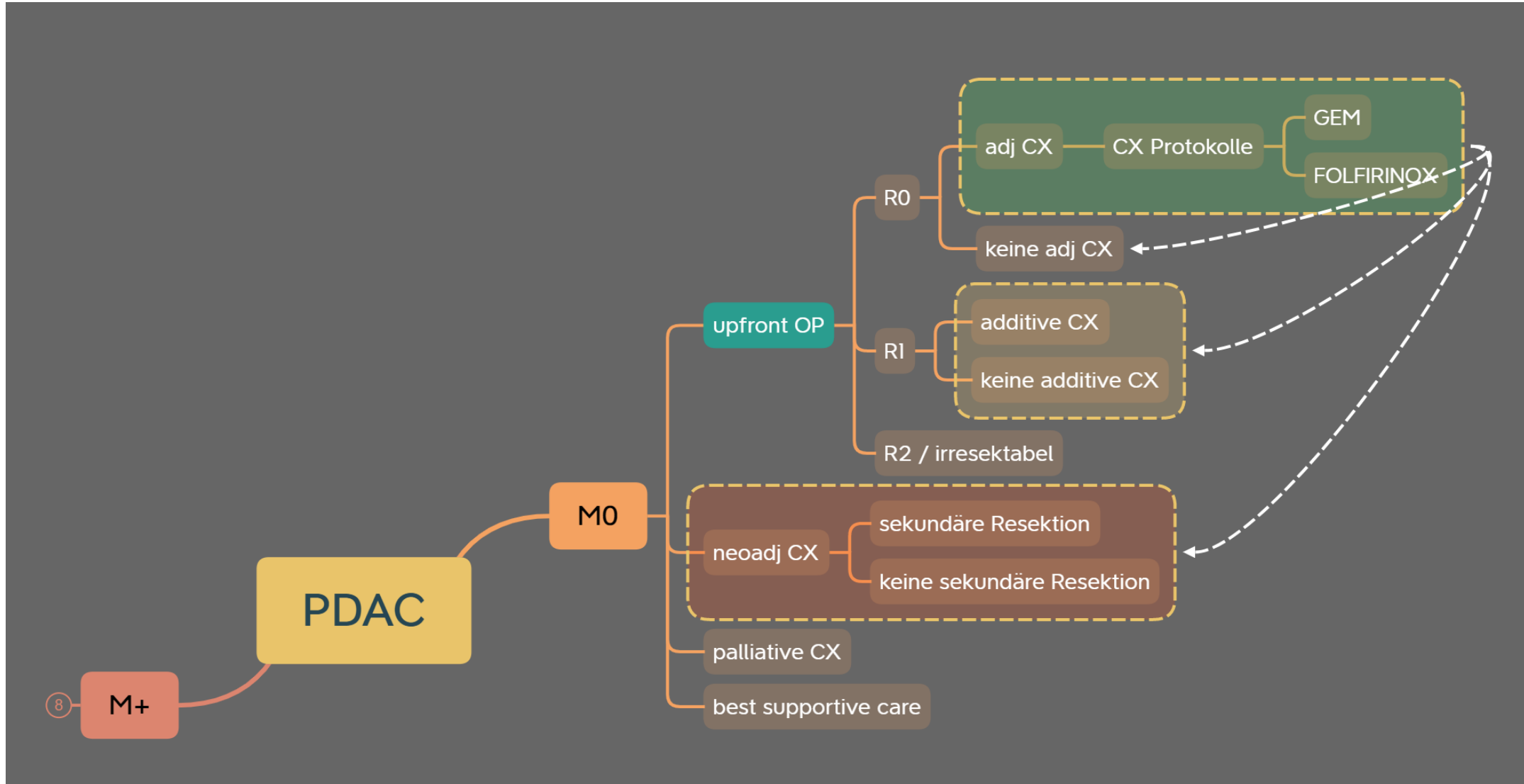
PDAC M0 upfront R0: adj. Protokolle



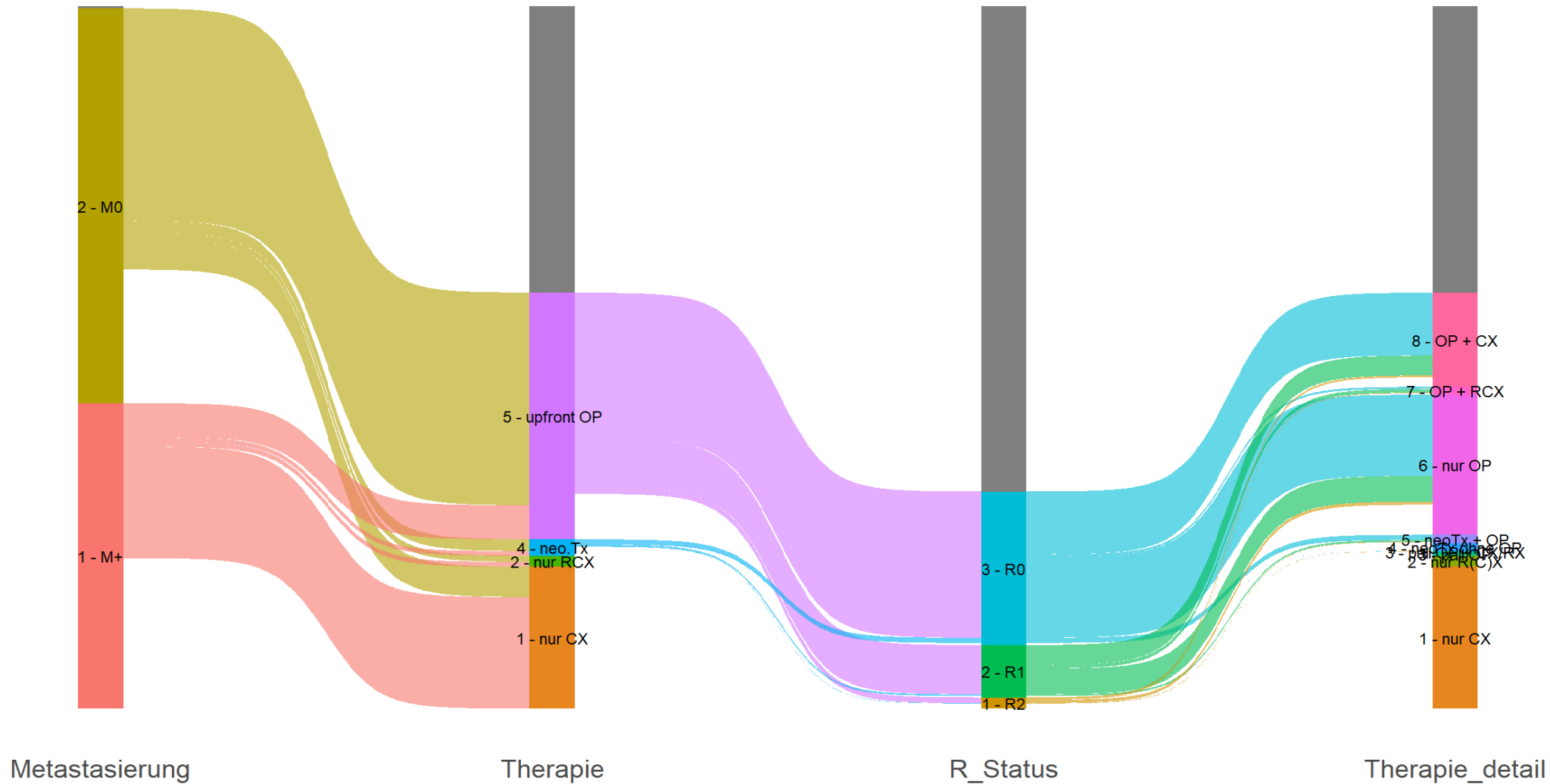
PDAC M0 upfront R0: adj. Therapie



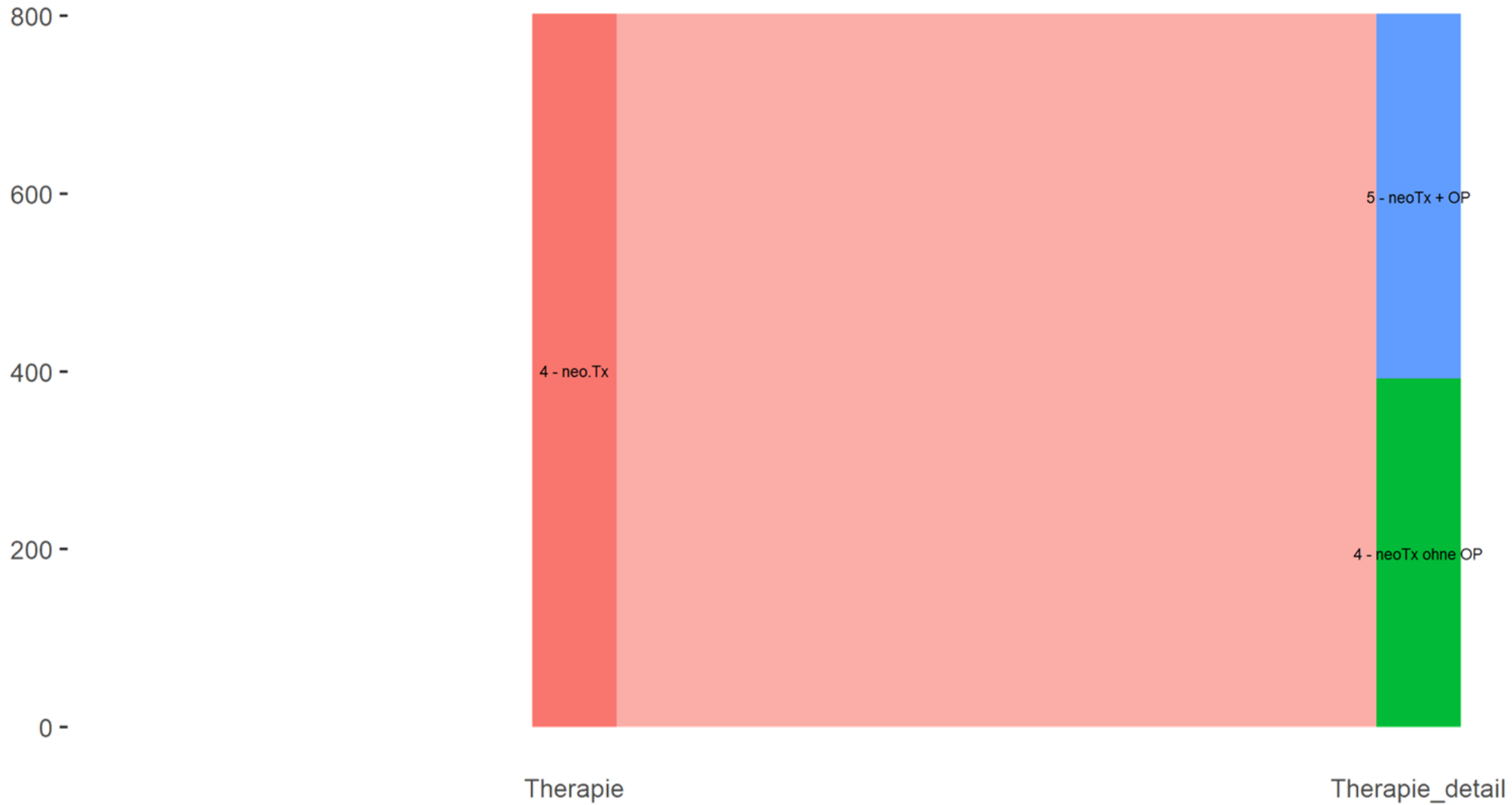
PDAC M0: neoadjuvant vs upfront OP



PDAC M0: neoadjuvant vs upfront OP

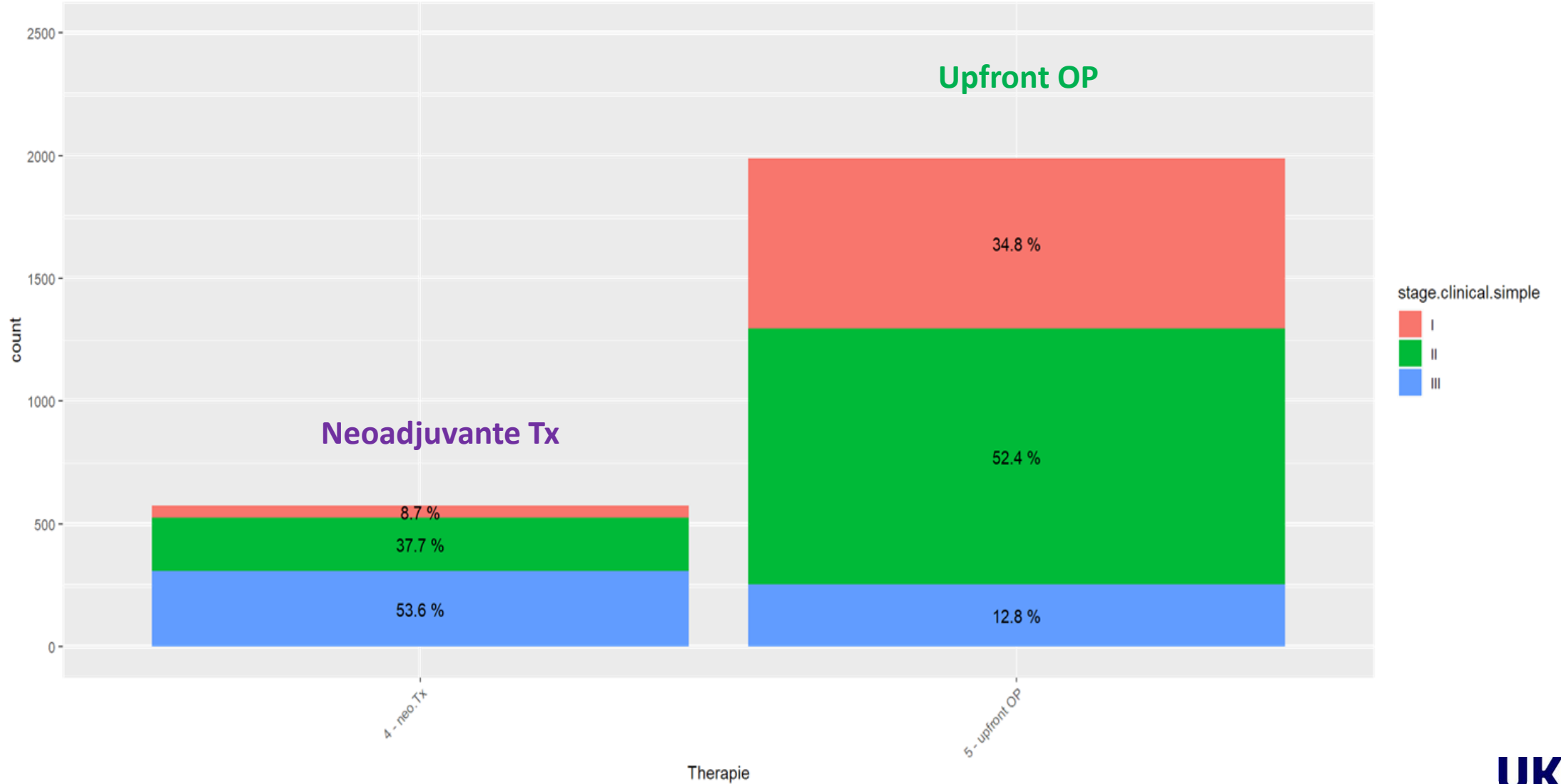


PDAC M0: neoadjuvant vs upfront OP

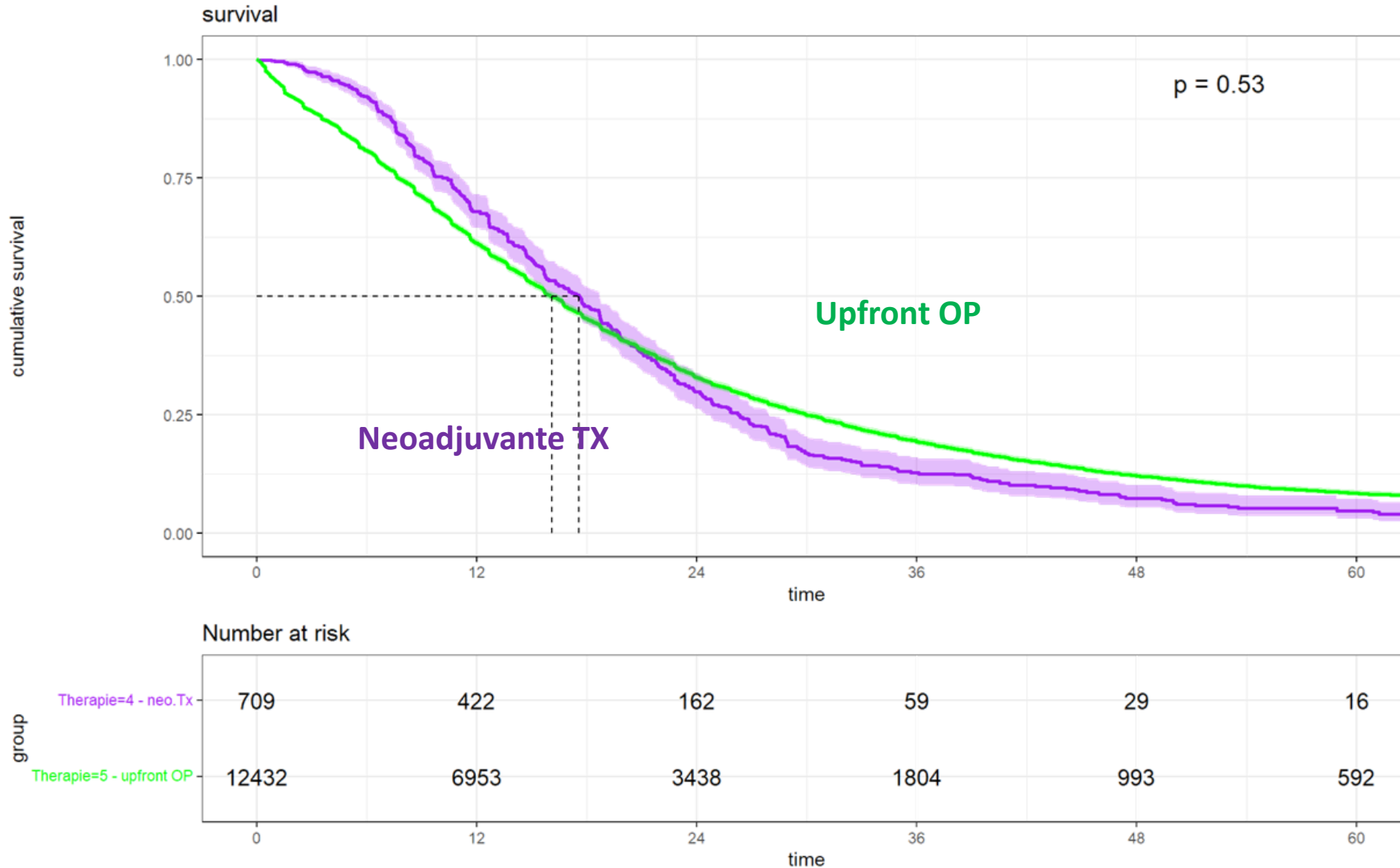


PDAC M0: neoadjuvant vs upfront OP

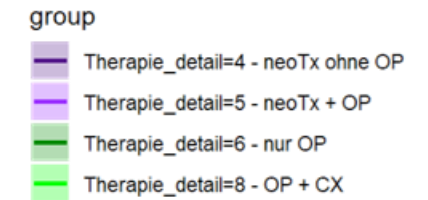
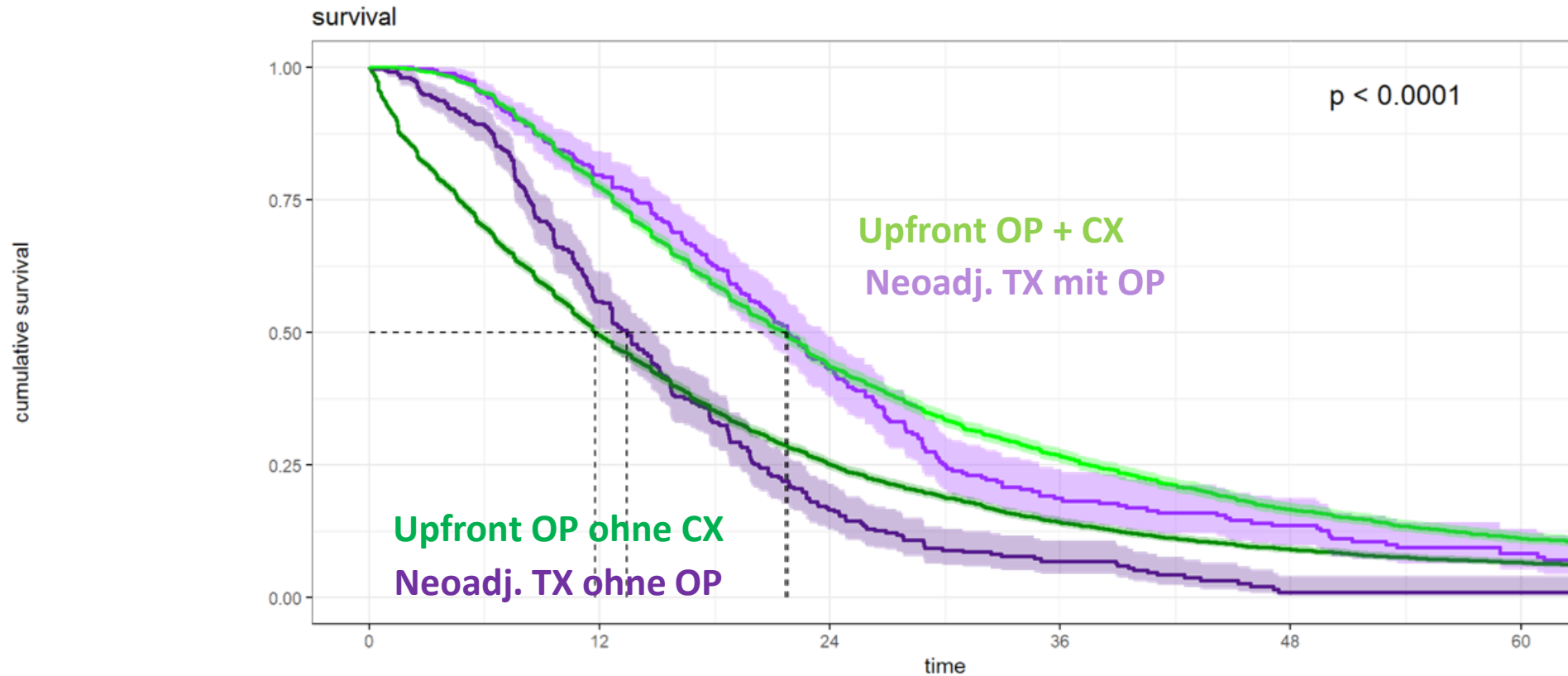
PDAC M0 upfront OP vs neoadj
n = 2564



PDAC M0: neoadjuvant vs upfront OP



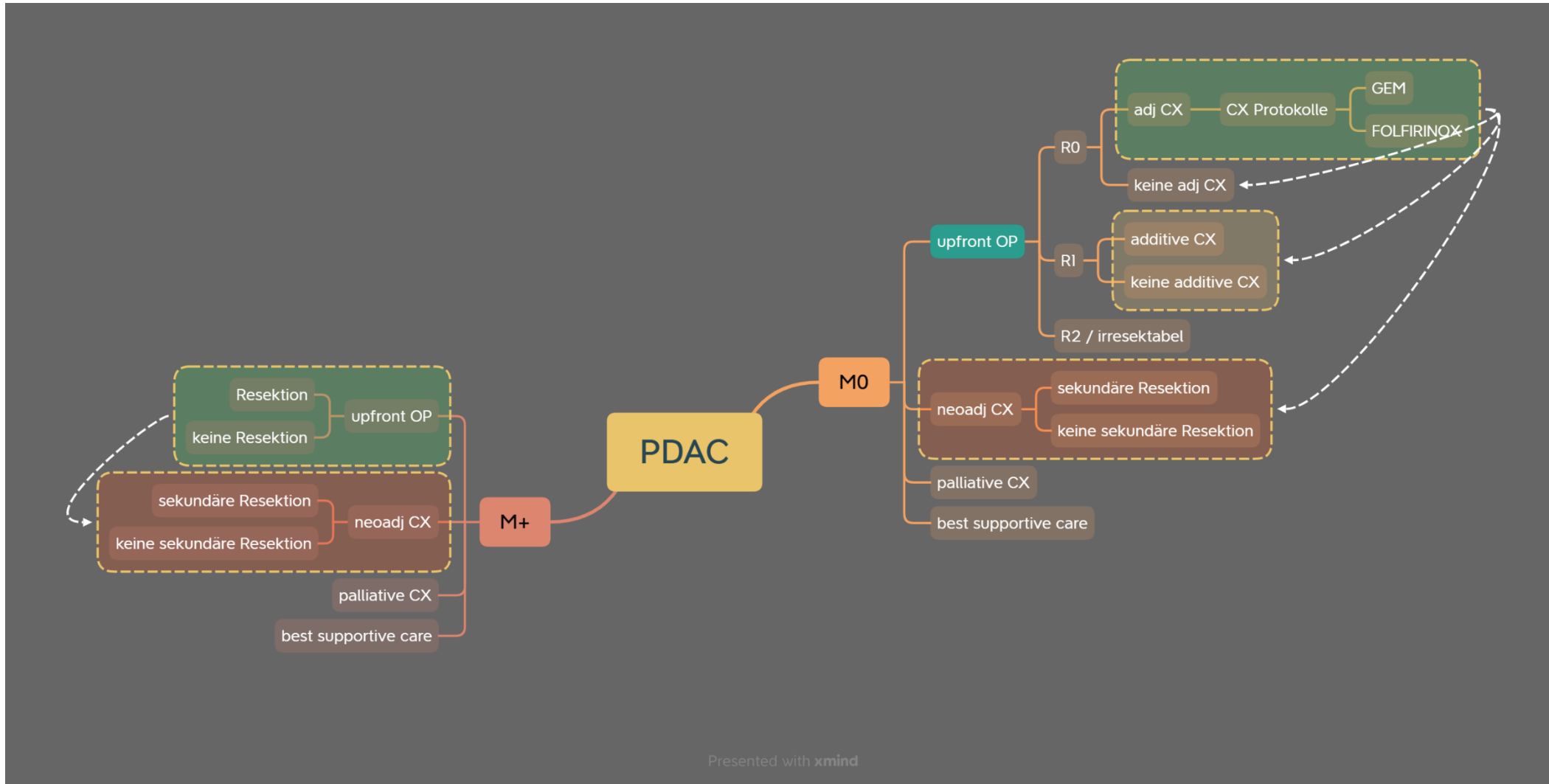
PDAC M0: neoadjuvant vs upfront OP



Number at risk

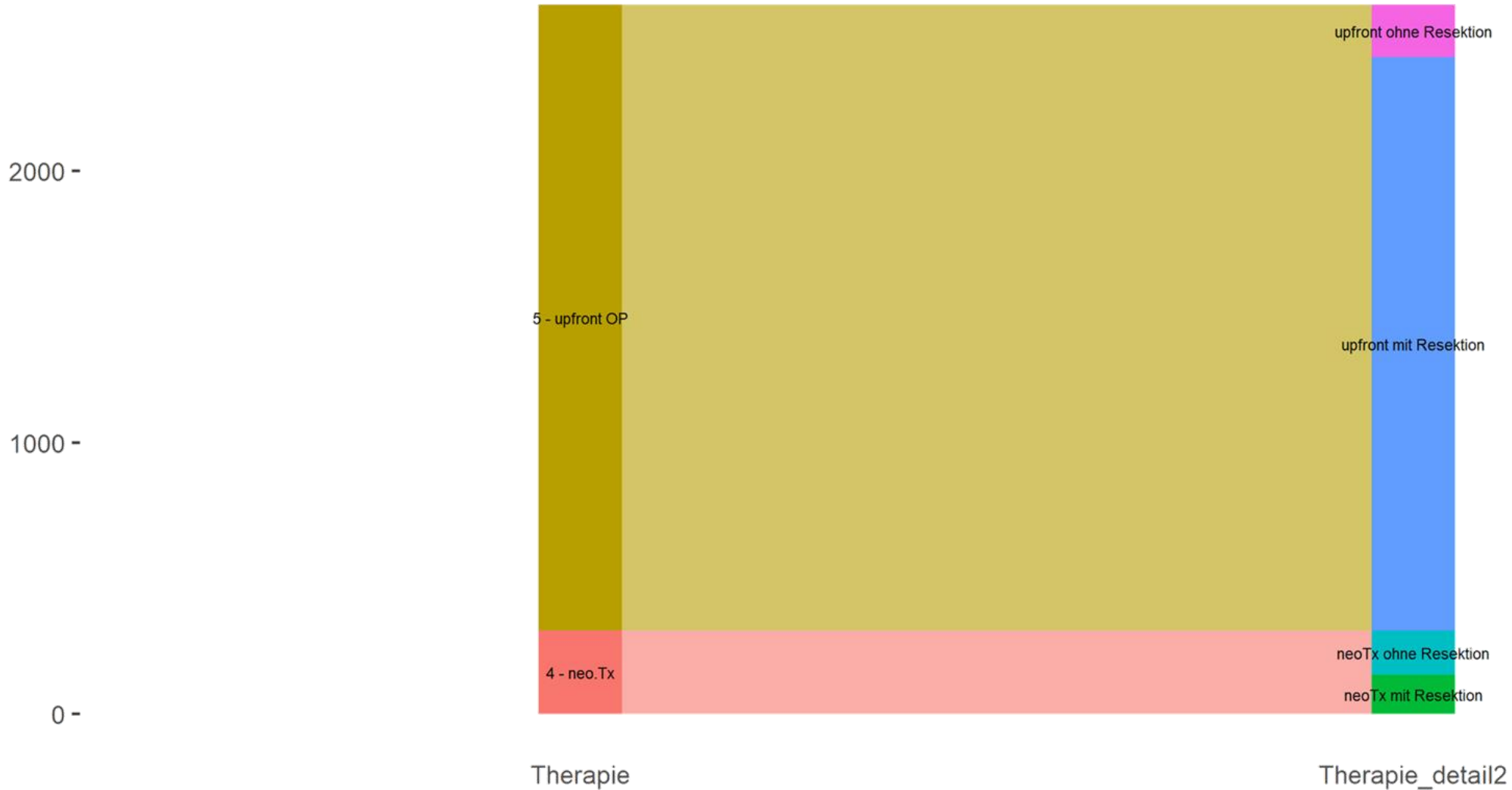
group	0	12	24	36	48	60
Therapie_detail=4 - neoTx ohne OP	353	174	46	16	2	2
Therapie_detail=5 - neoTx + OP	356	248	116	43	27	14
Therapie_detail=6 - nur OP	7101	3168	1500	758	423	263
Therapie_detail=8 - OP + CX	4790	3443	1764	957	522	301

PDAC M+: neoadjuvant vs upfront OP

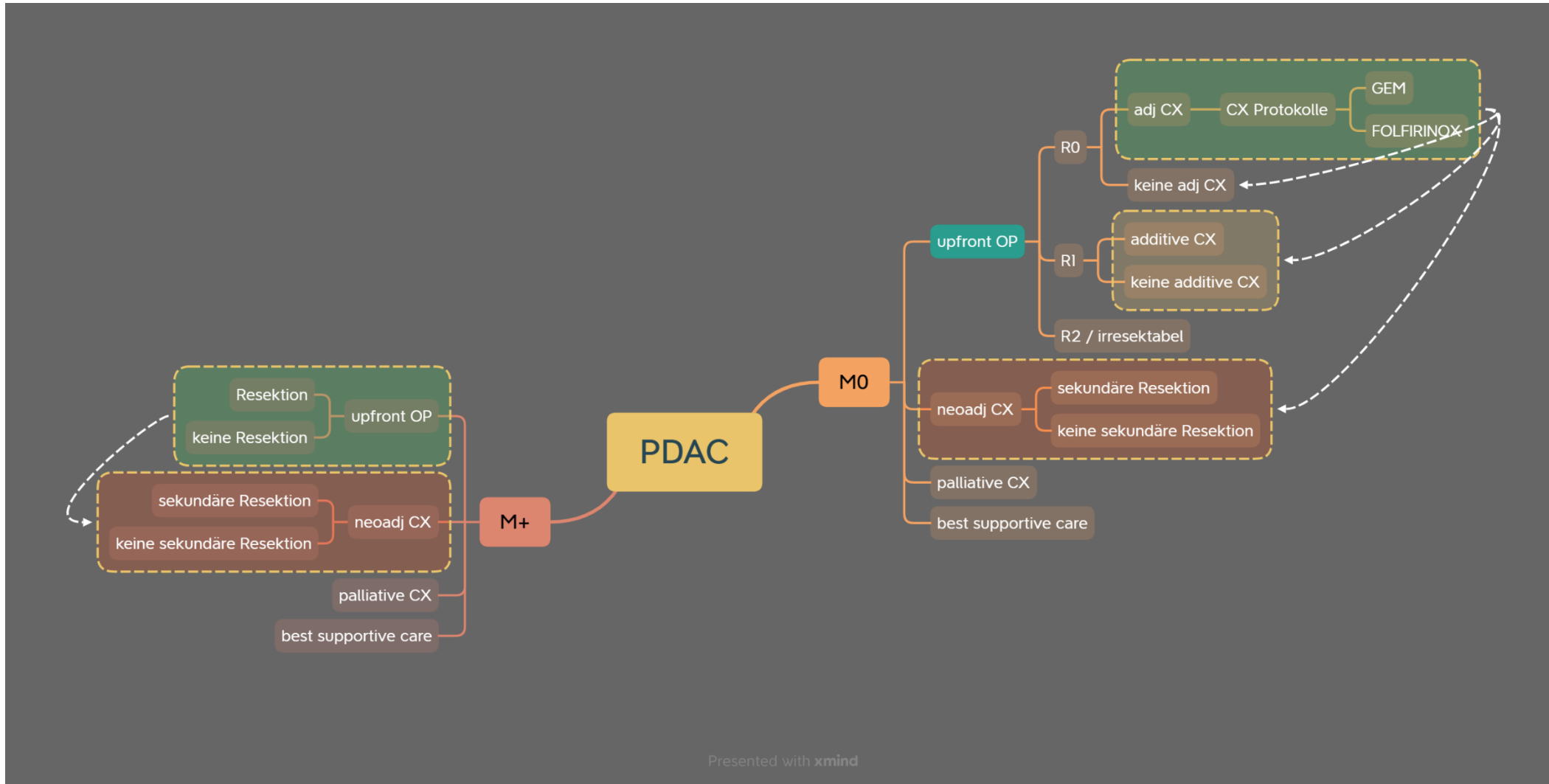


Presented with xmind

PDAC M+: neoadjuvant vs upfront OP

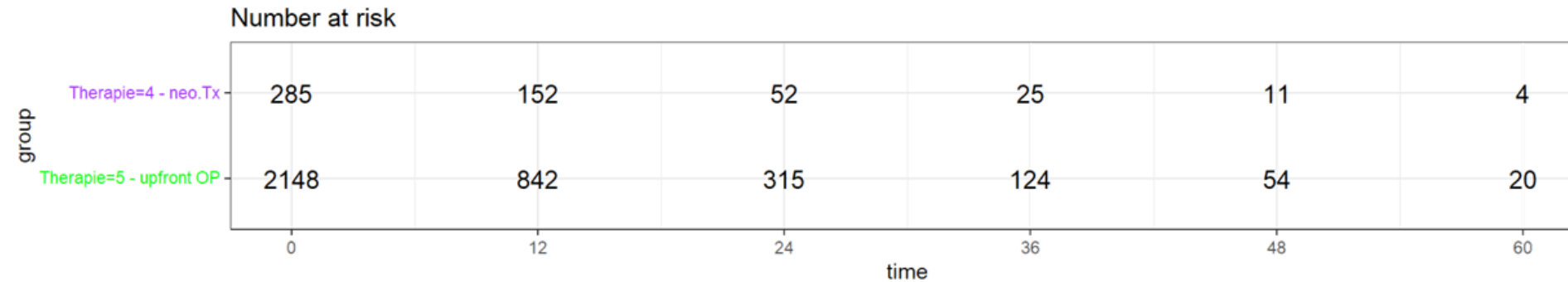
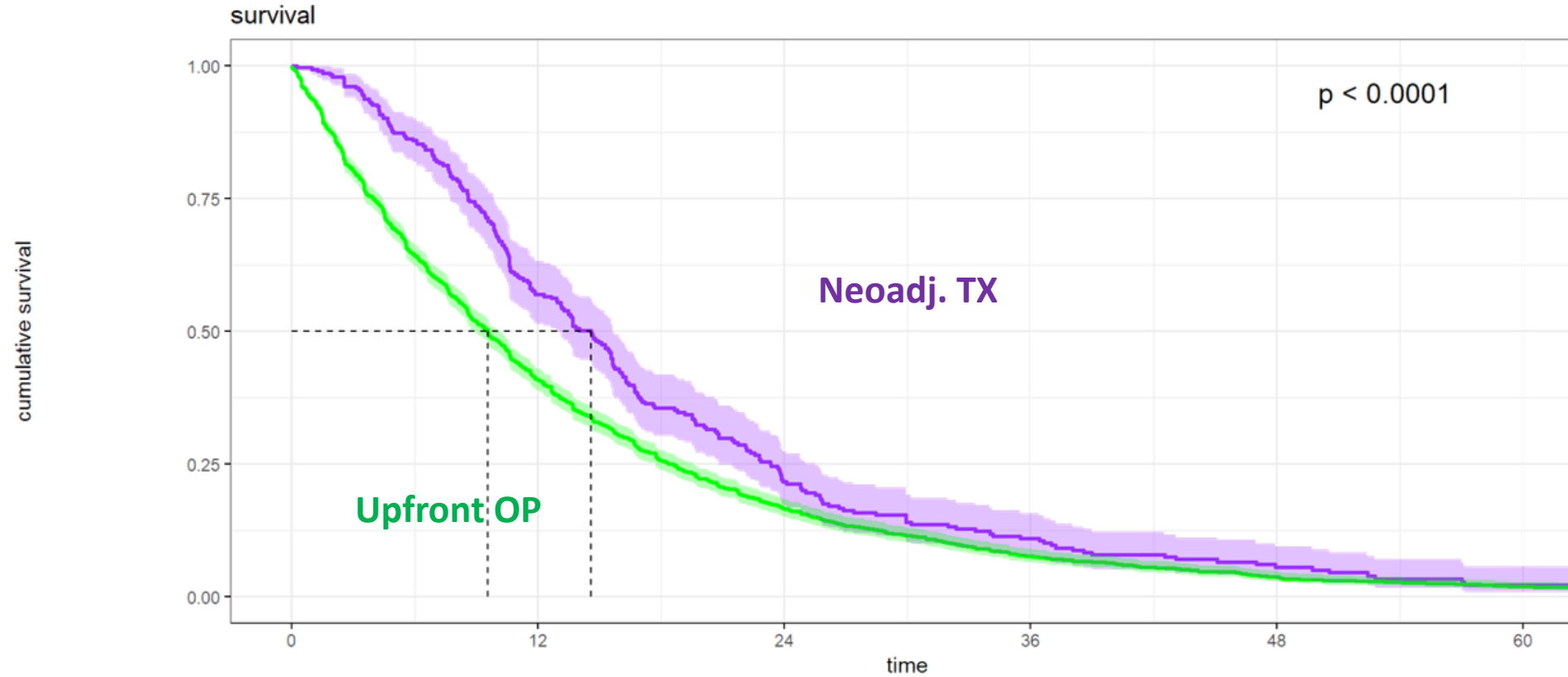


PDAC M+: neoadjuvant vs upfront OP

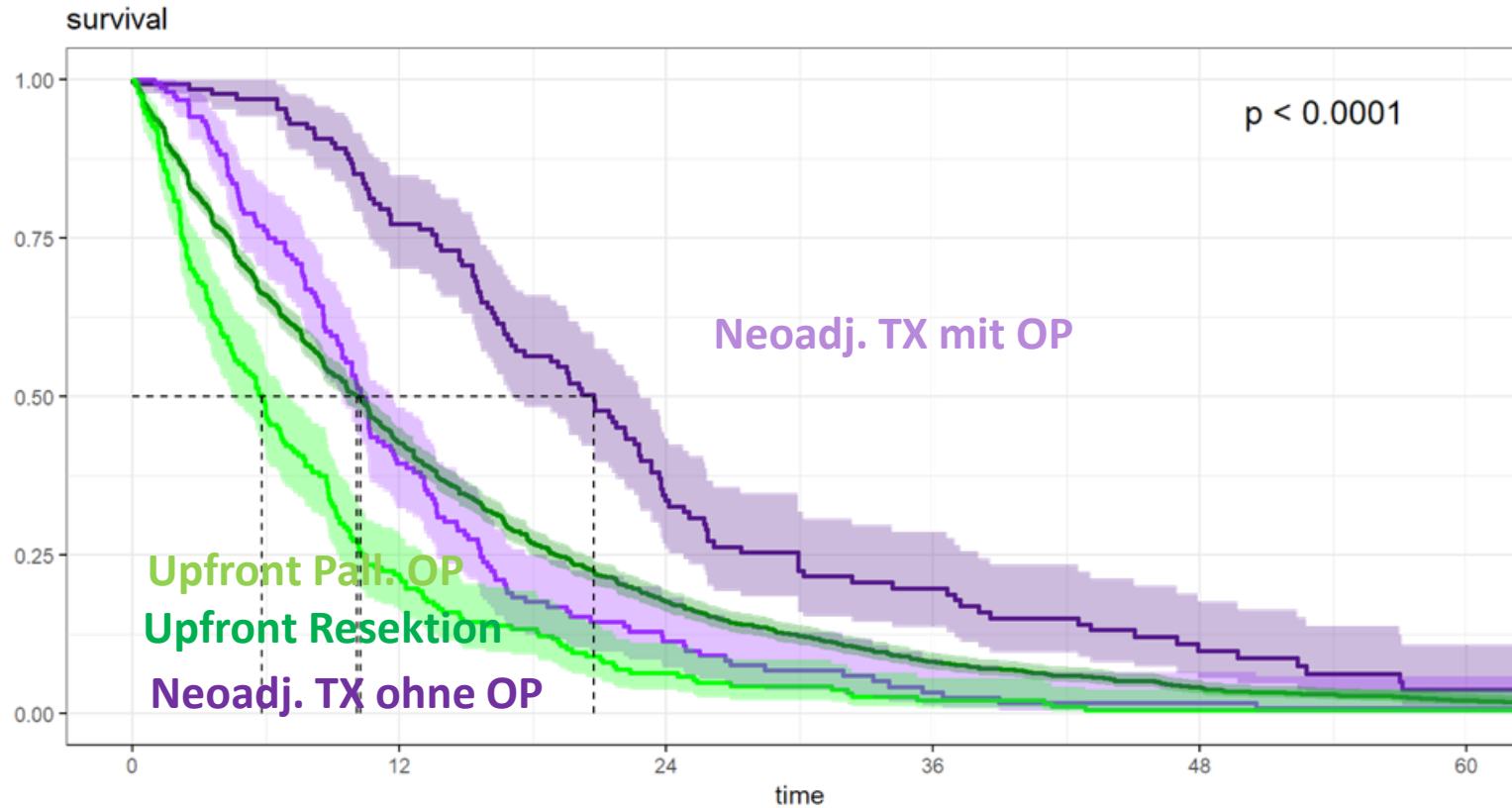


Presented with xmind

PDAC M+: neoadjuvant vs upfront OP



PDAC M+: neoadjuvant vs upfront OP



Number at risk

group	0	12	24	36	48	60
Therapie_detail2=neoTx mit Resektion	132	96	37	21	9	3
Therapie_detail2=neoTx ohne Resektion	153	56	15	4	2	1
Therapie_detail2=upfront mit Resektion	1959	801	303	120	53	19
Therapie_detail2=upfront ohne Resektion	189	41	12	4	1	1

time

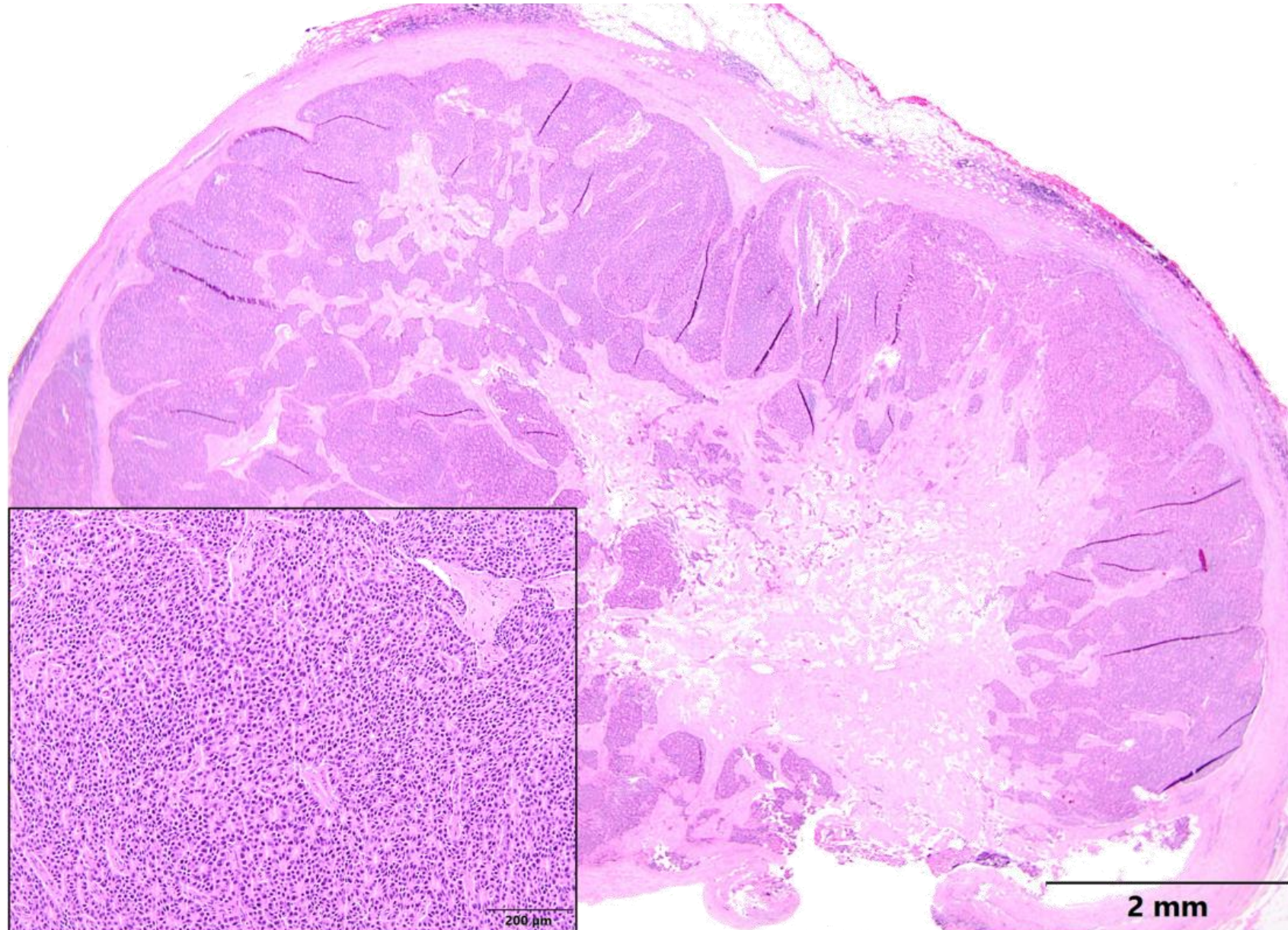
Krebsregisterdaten = valide „Real World Data“

Cave retrospektive Daten: selection bias !

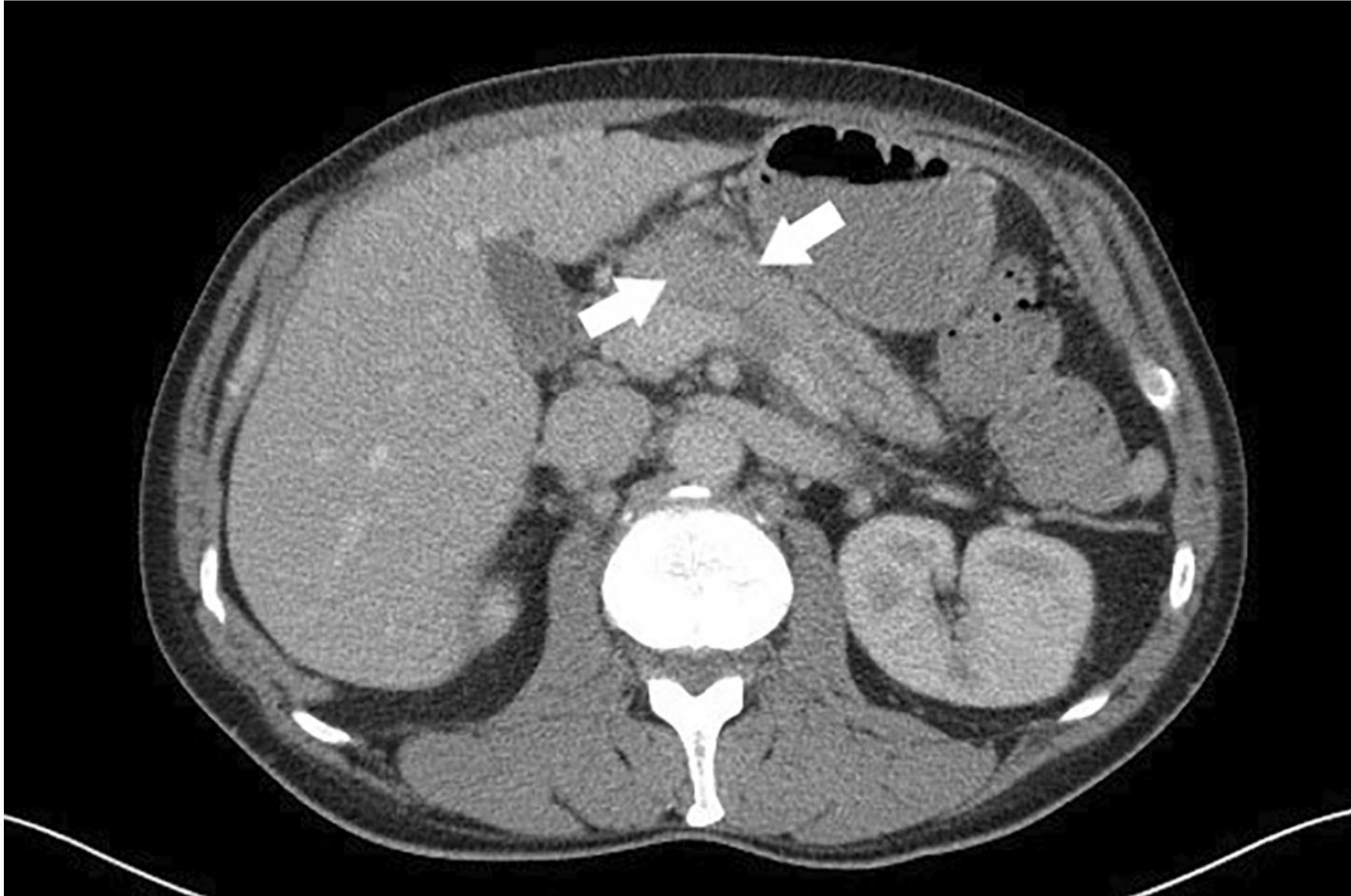
Interpretation für Pankreaskarzinom:

- die beste Therapie ist **multimodal**: Resektion UND Chemotherapie
nur **ca. 40%** der Patienten erhalten adjuvante / additive Tx
-> periOP 90-Tages Mortalität (>5%) als Surrogat für periOP Komplikationen
-> neoadjuvant als Alternative ?
- **neoadjuvante Tx**: mindestens gleichwertig zur adjuvanten Tx
beim lokal fortgeschrittenen PankreasCA sinnvoll
biologische Selektion für Resektion im Stadium IV

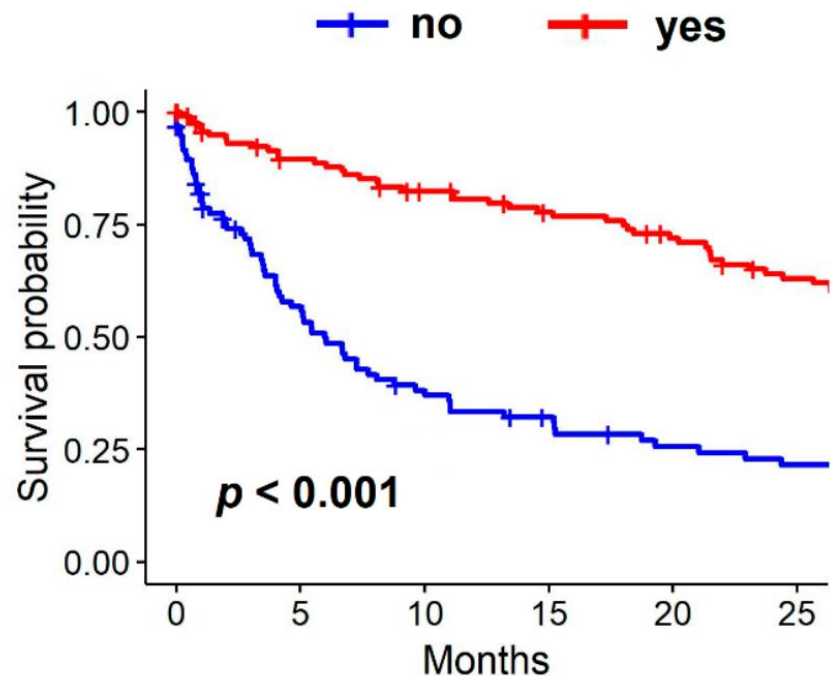
AzinuszellCA



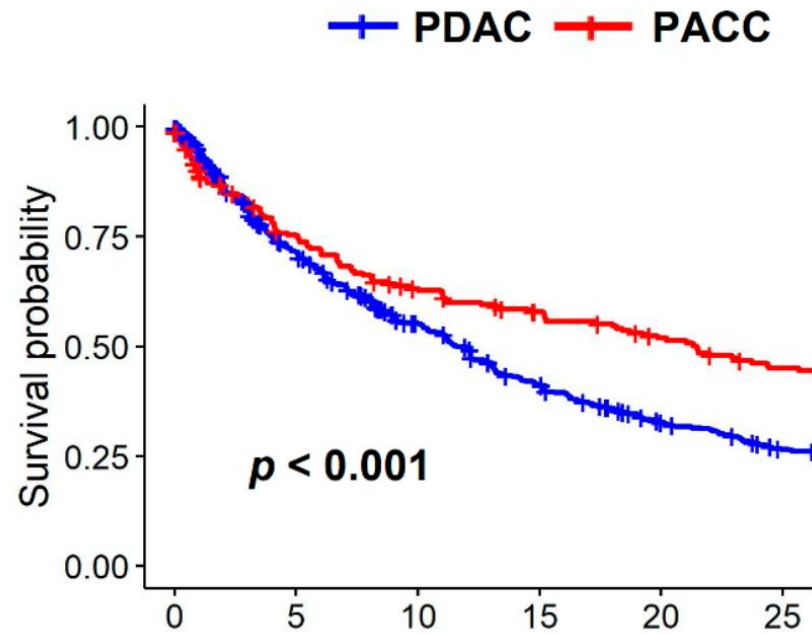
AzinuszellCA



E. PACC: Resection



A. Overall PACC vs PDAC



Hintergrund

Muzinöse Adenokarzinome des Pankreas (MACP)

- Definition (WHO): > 80% Muzin-Pools
- 1-3 % aller Pankreastumore

- Besseres Langzeit-Outcome im Vergleich zu duktalem Adenokarzinom in NCDB- Analyse.

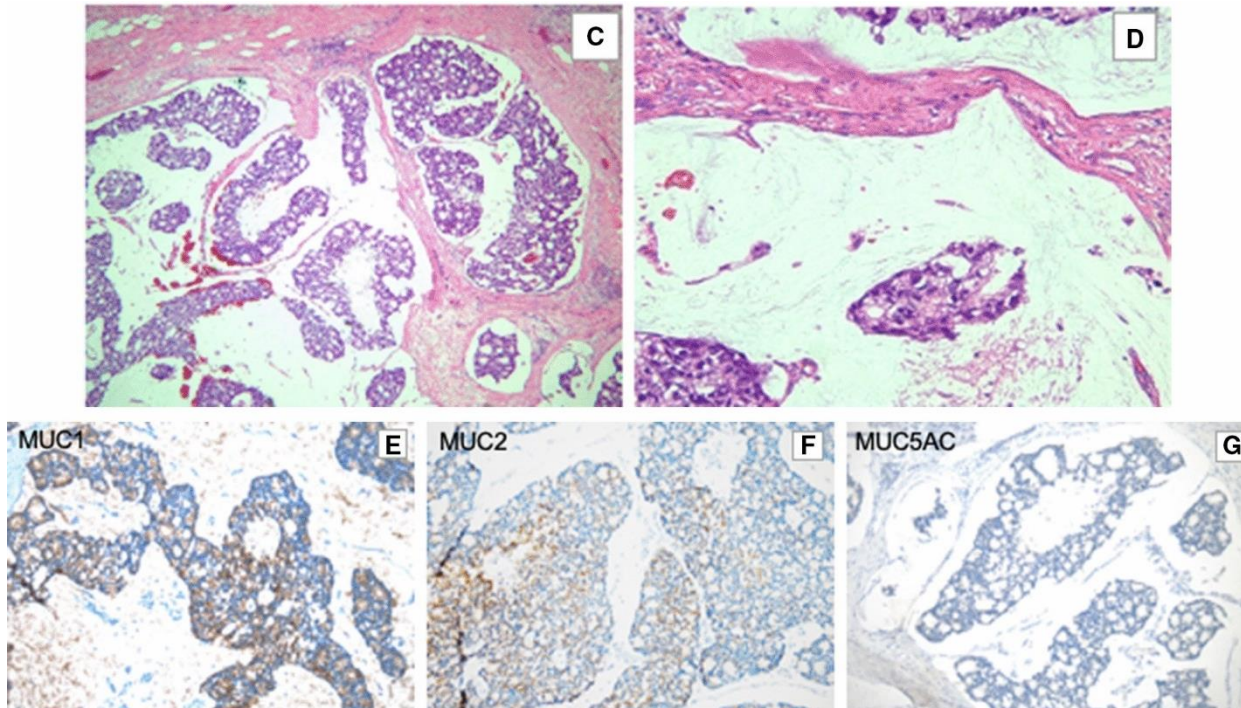
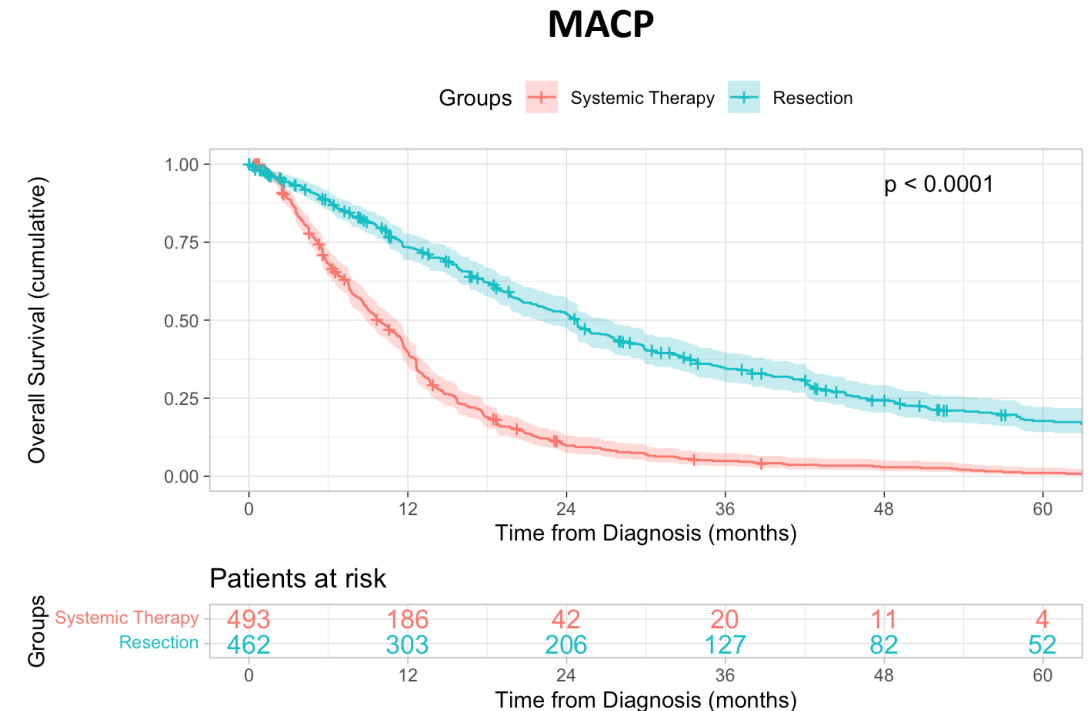


Abbildung aus Yasuoka et al.

Kollidales PankreasCA

Demografie + Tx

Parameter	N (% of total)/		p- Wert
	median (min - max) / mean (SD)		
	MACP	PDAC	
Alle Patient:innen			
Patientenzahl	1847	32234	
Geschlecht			0.049
Männlich	1008 (54.6)	16822 (52.2)	
Weiblich	839 (45.4)	15411 (47.8)	
missing	0 (0)	1 (< 0.001)	
Medianes Alter (Jahre)	68.9 (10.0)	69.4 (10.0)	0.063
Fernmetastasen			< 0.001
M0	633 (42.2)	17804 (65.9)	
M1	868 (57.8)	9218 (34.1)	
missing	346 (18.7)	5212 (16.2)	
Behandlungsstrategie			< 0.001
(Radio-)Chemotherapie	491 (49.3)	5456 (26.2)	
Alleinige Resektion	243 (24.4)	7285 (35.0)	
Resektion + Adjuvanz	226 (22.7)	6983 (33.6)	
Neoadjuvanz + Resektion	20 (2.0)	572 (2.7)	
Neoadjuvanz ohne Resektion	16 (1.6)	493 (2.4)	
Palliative Chirurgie + (radio-)Chemotherapie	0 (0)	18 (0.1)	
missing	851 (46.1)	11427 (35.5)	



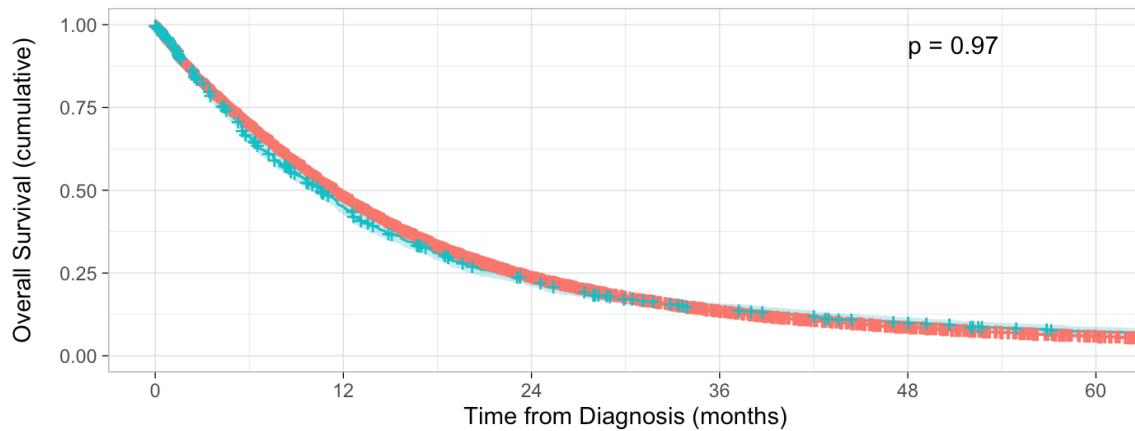
Kollidales PankreasCA

Langzeit-Überleben

Overall Cohort

n (MACP) = 1847; n (PDAC) = 32234

Groups PDAC MACP



Medianes Overall Survival (in Monaten):

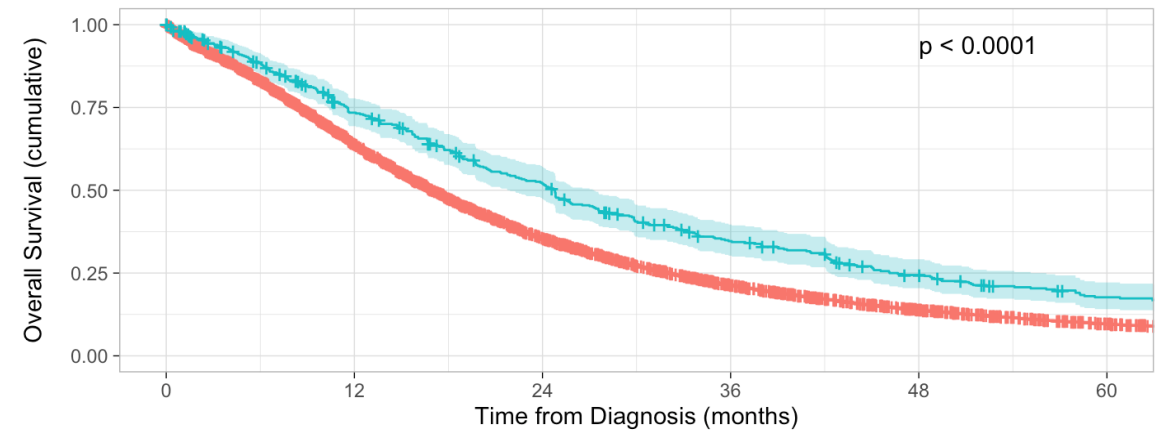
MACP: 10.6 (9.8 – 11.4)

PDAC: 11.6 (11.4 – 11.7)

Resected Patients

n (MACP) = 489; n (PDAC) = 14840

Groups PDAC MACP



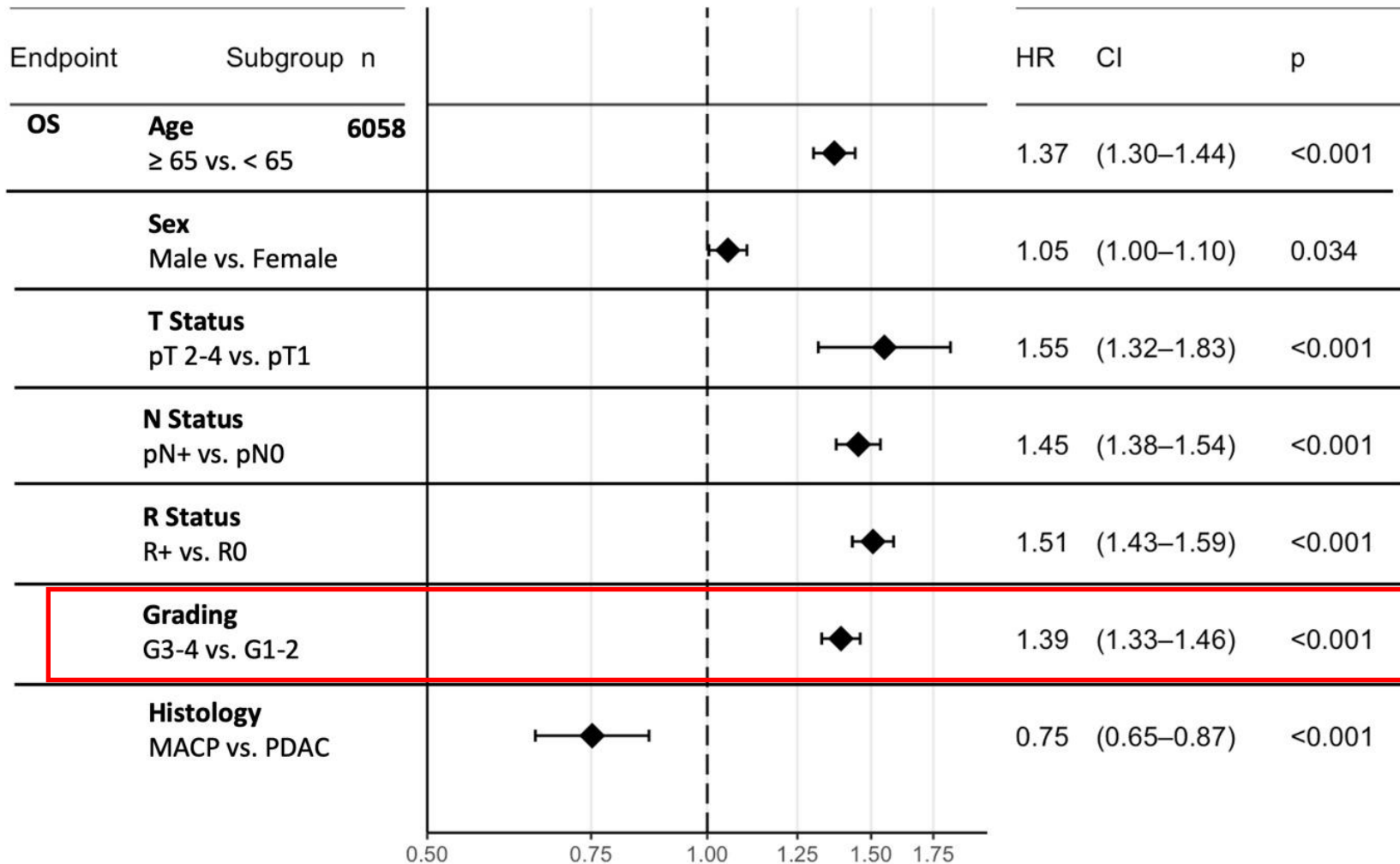
Medianes Overall Survival (in Monaten):

MACP: 24.8 (21.8 – 27.3)

PDAC: 17.0 (16.7 – 17.4)

Langzeit-Überleben nach Resektion

Surgical Cohort



AmpullenCA

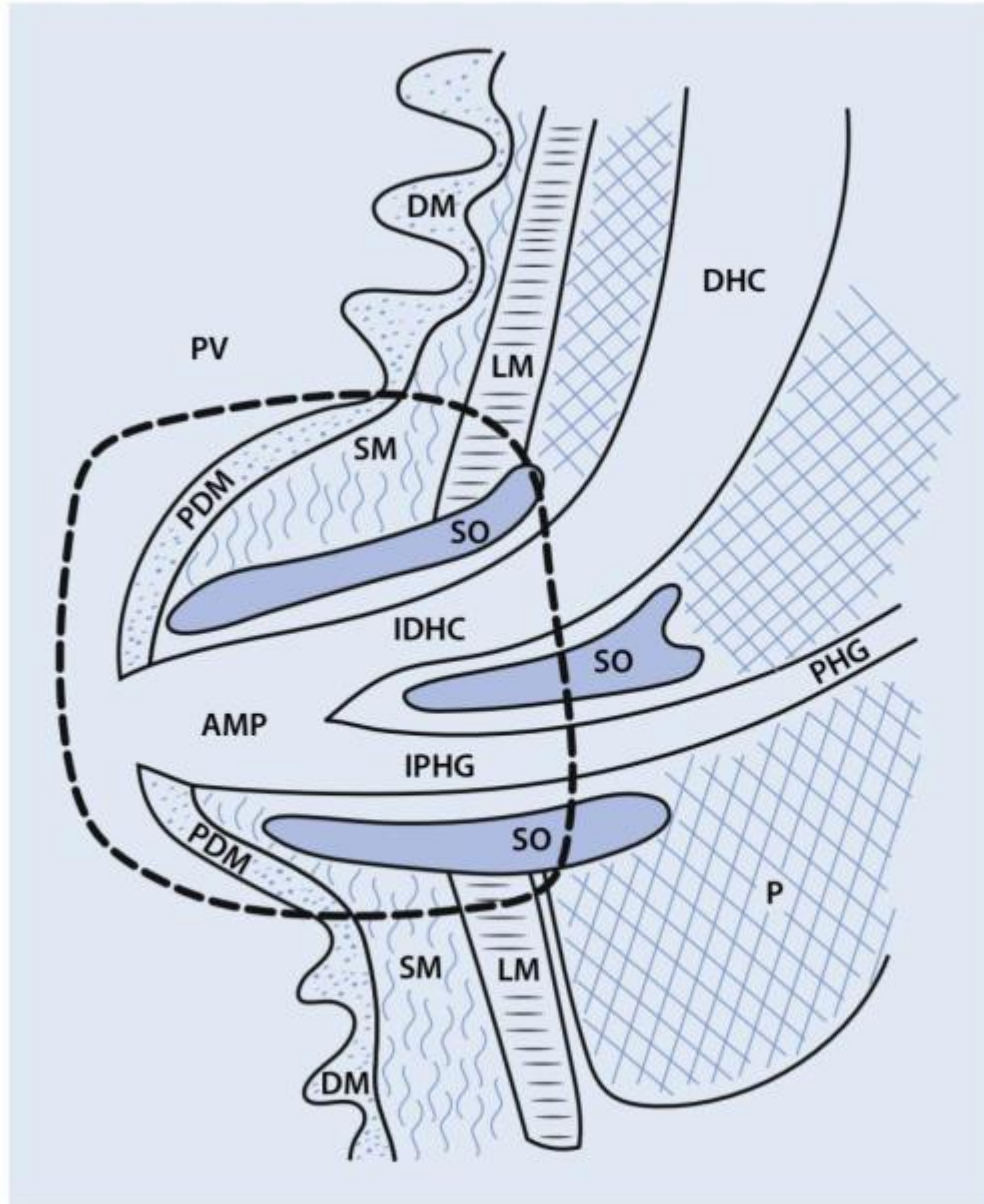
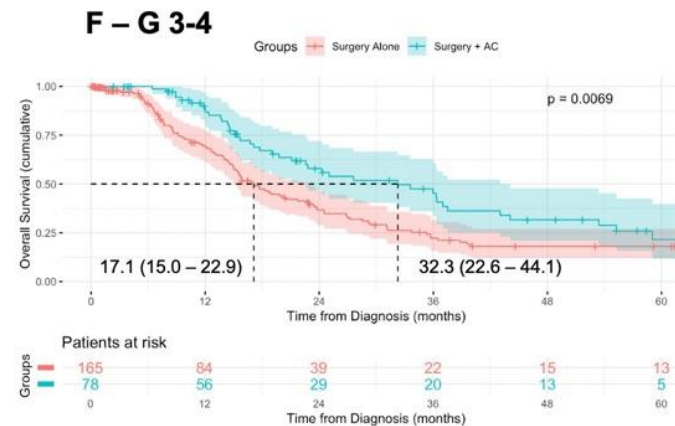
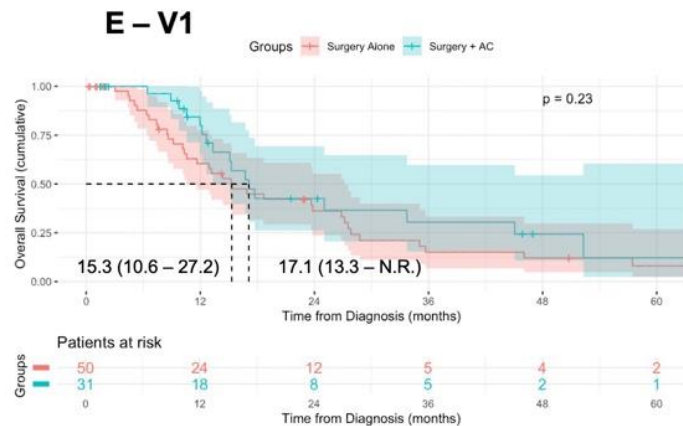
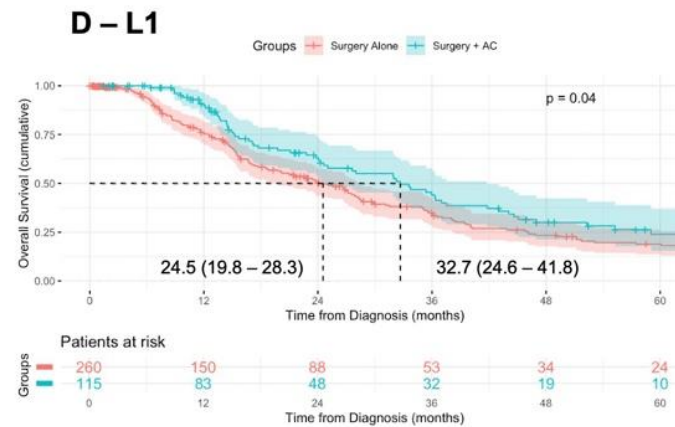
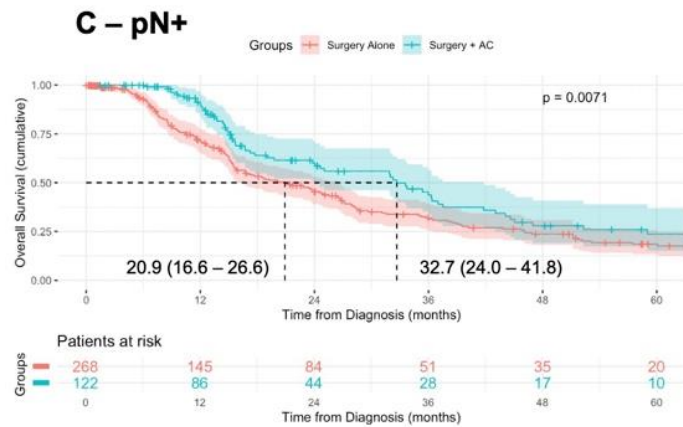
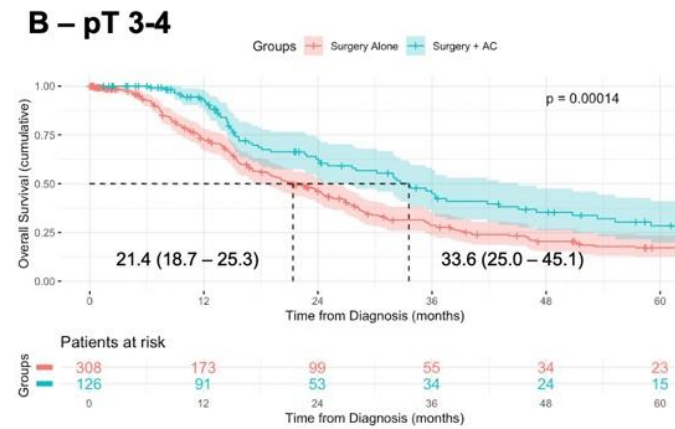
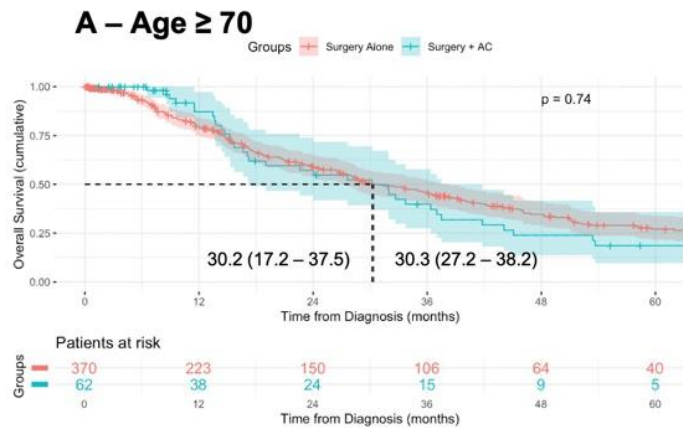
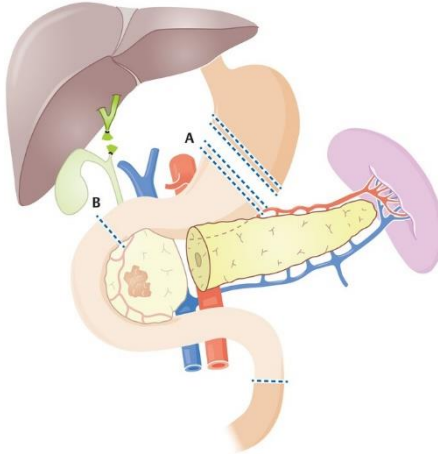


Abb. 1 ◀ Anatomie der Papilla Vateri. Die unterbrochene Linie umgrenzt die Papilla Vateri. Nur in ca. 20 % der Fälle existiert ein Ampullenkanal, eine „typische“ Ampulle nur in 3 %. AMP Ampullenkanal/Ampulla Vateri, (I)DHC (intra-duodenaler) Ductus hepatocholedochus, (I)PHG (intra-duodenaler) Pankreashauptgang, LM Lamina muscularis, P Pankreas, (P)DM (papilläre) duodenale Mukosa, PV Papilla Vateri, SM Submukosa, SO Sphincter Oddi



AmpullenCA

Adjuvante Therapie



Grützmann R et al., Thieme 2021

Pro Pancreatoduodenectomy (PD)

- Less Trauma
- Less exocrine- and endocrine insufficiency
- Current standard procedure

?

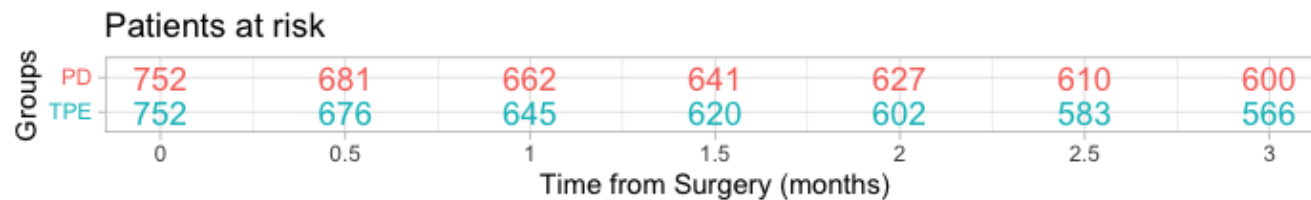
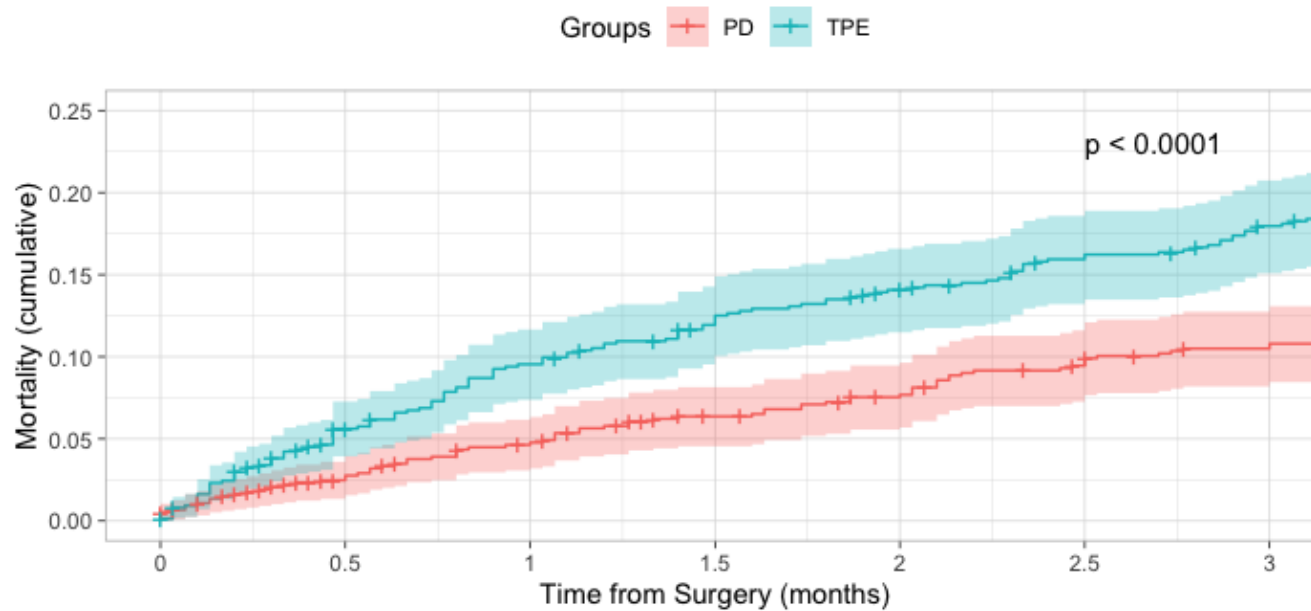
↔

20 % CR-POPF

Pro Total Pancreatectomy (TPE)

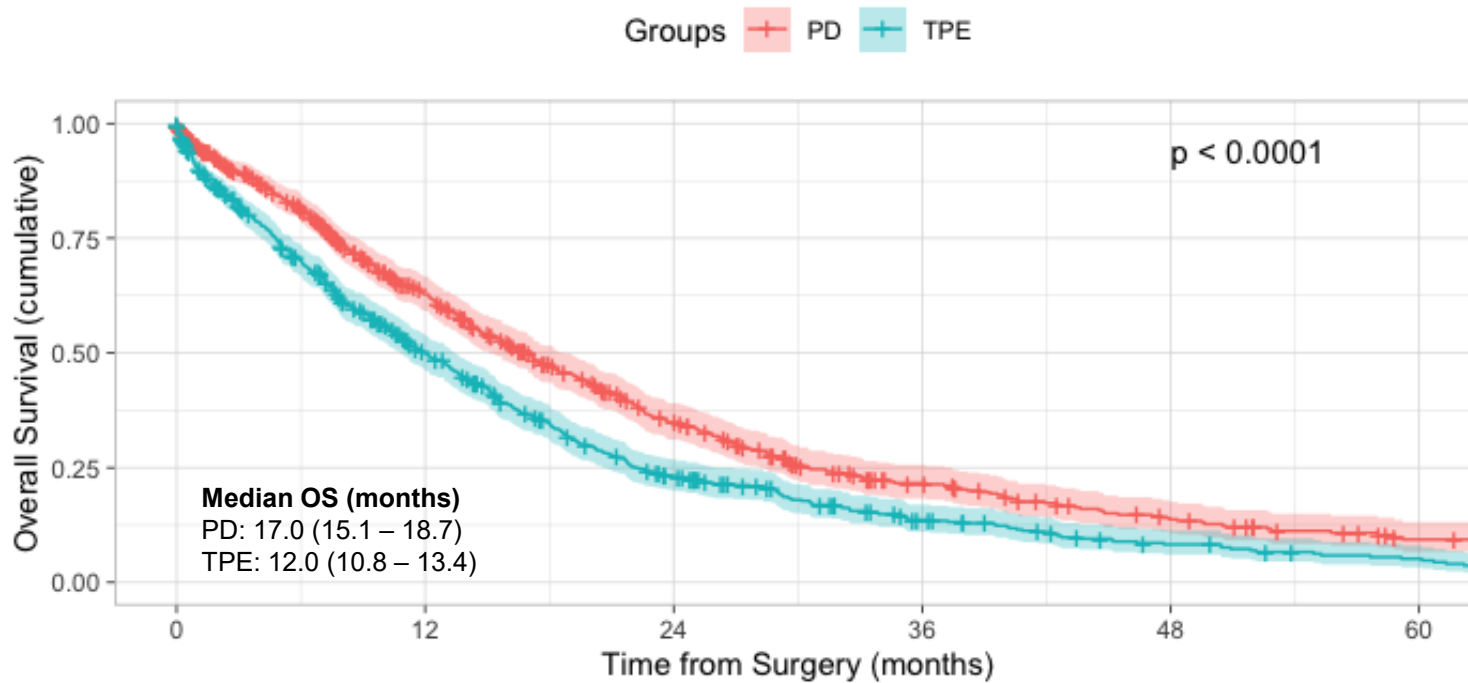
- More radical operation
→ Local recurrences ↓ ?
- No pancreateoenteric anastomosis (PJ/PG)
→ Postoperative Complications ↓ ?

Perioperative Mortality



	Mortality rate (percent) / 95%-Confidence Interval		p-value
	PD	TPE	
30-day Mortality	4.8 (3.4 – 6.5)	9.5 (7.5 – 12.0)	< 0.001
90-day Mortality	11.0 (8.6 – 13.0)	18.0 (15.0 – 21.0)	< 0.001

Long-term Overall Survival



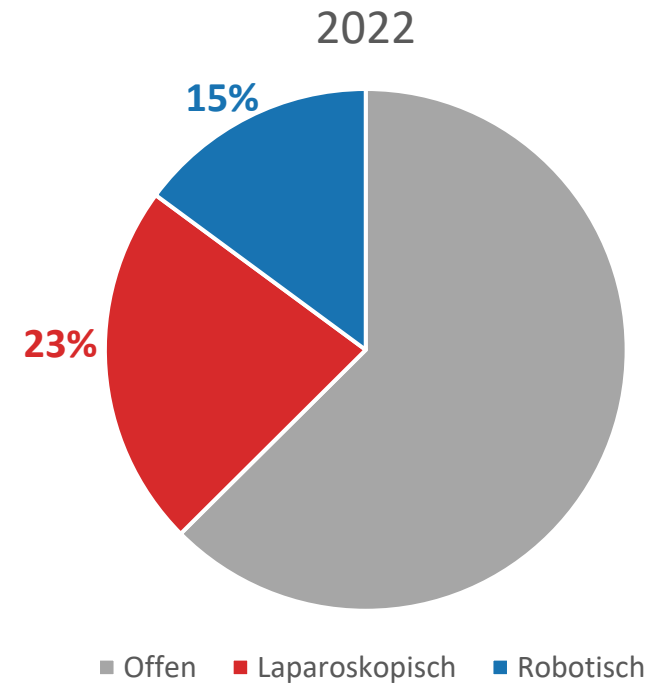
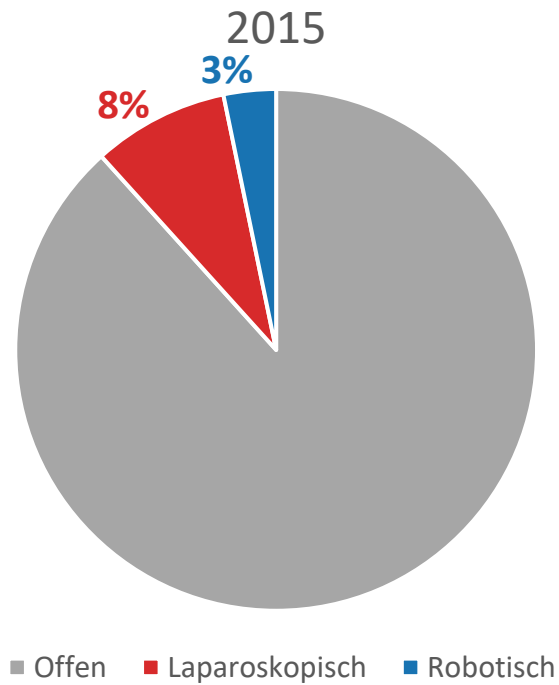
→ TPE associated with inferior long-term OS!

Patients at risk

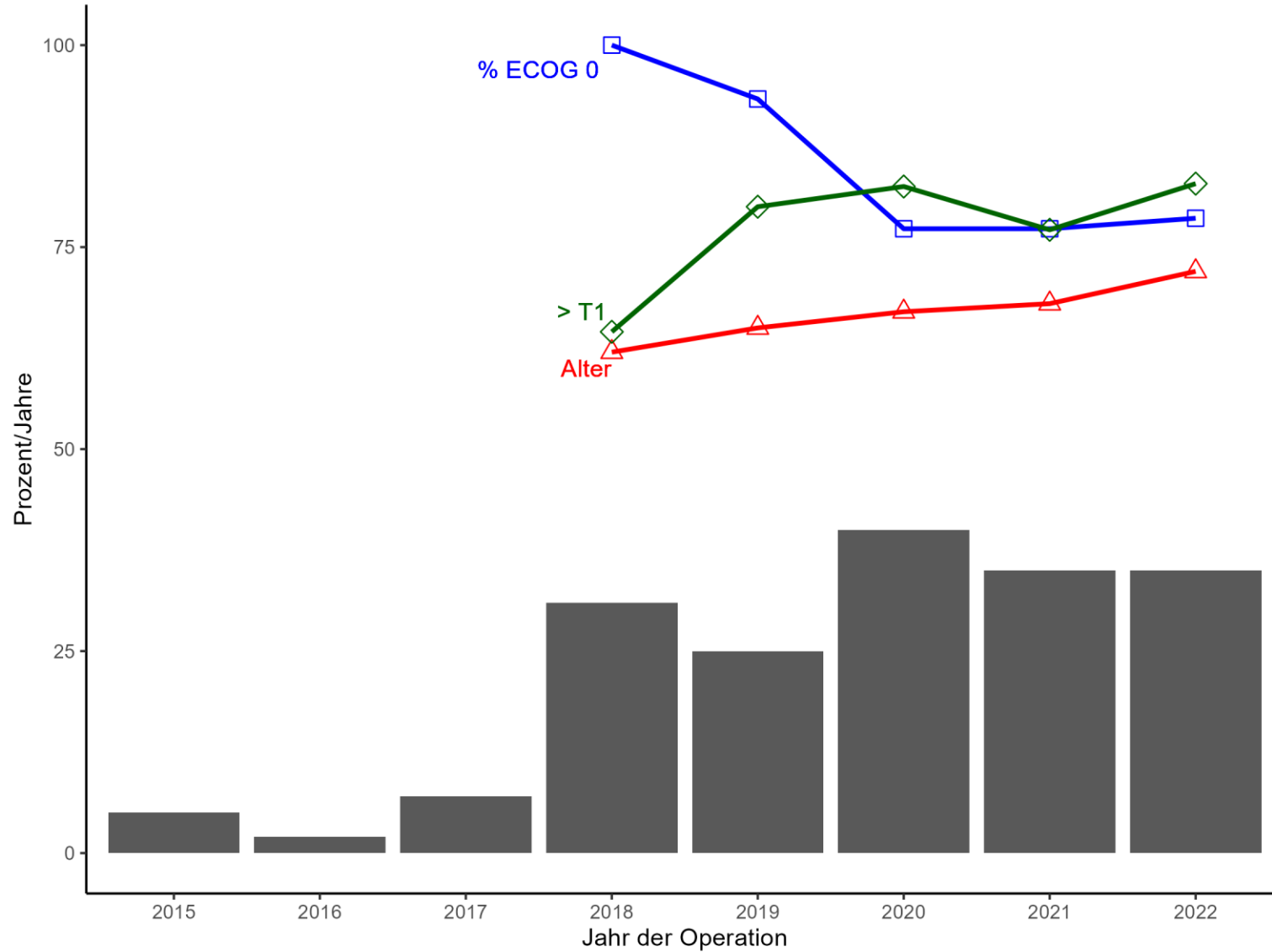
Groups	0	12	24	36	48	60
PD	752	364	172	79	41	18
TPE	752	311	127	55	26	14

Time from Surgery (months)

Pankreaslinksresektion

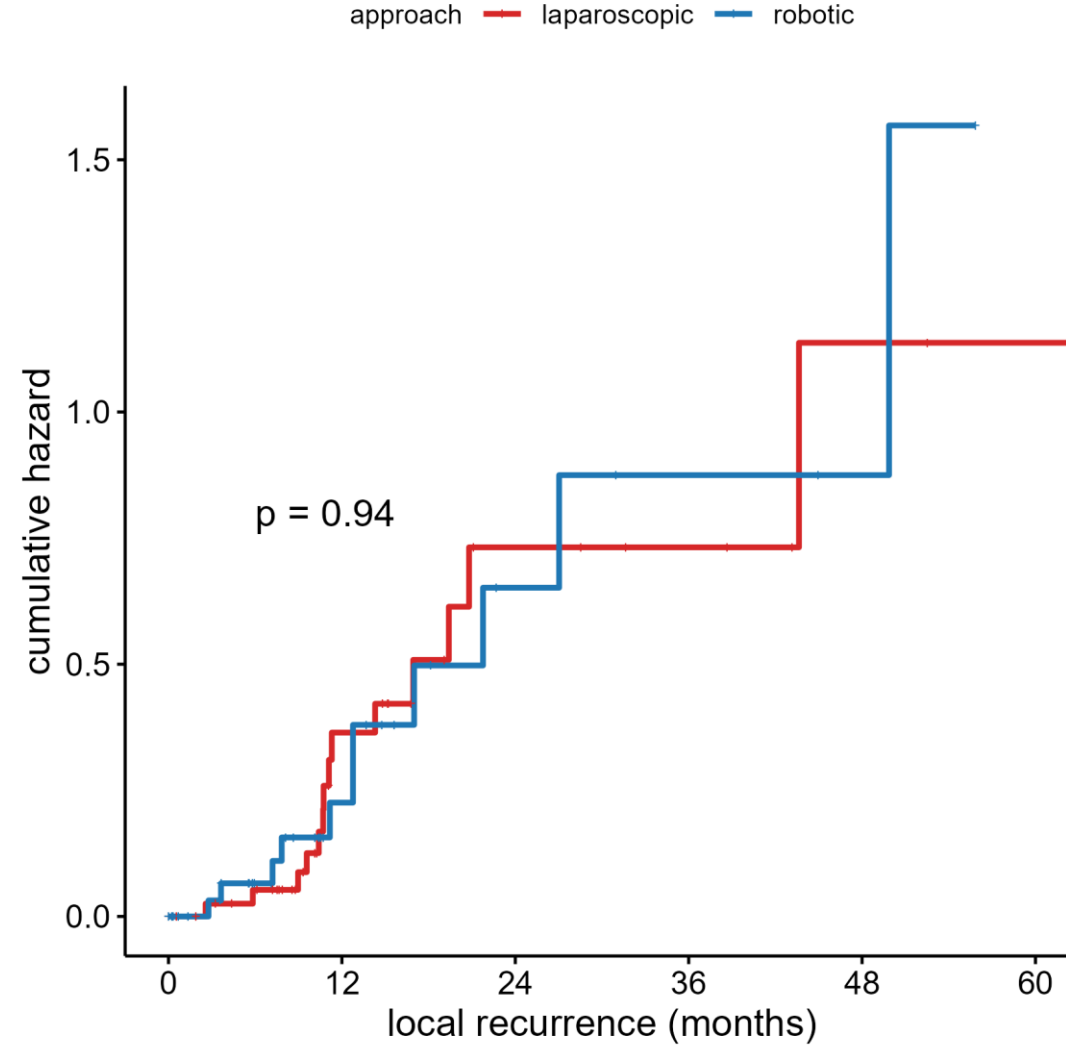


Pankreaslinksresektion



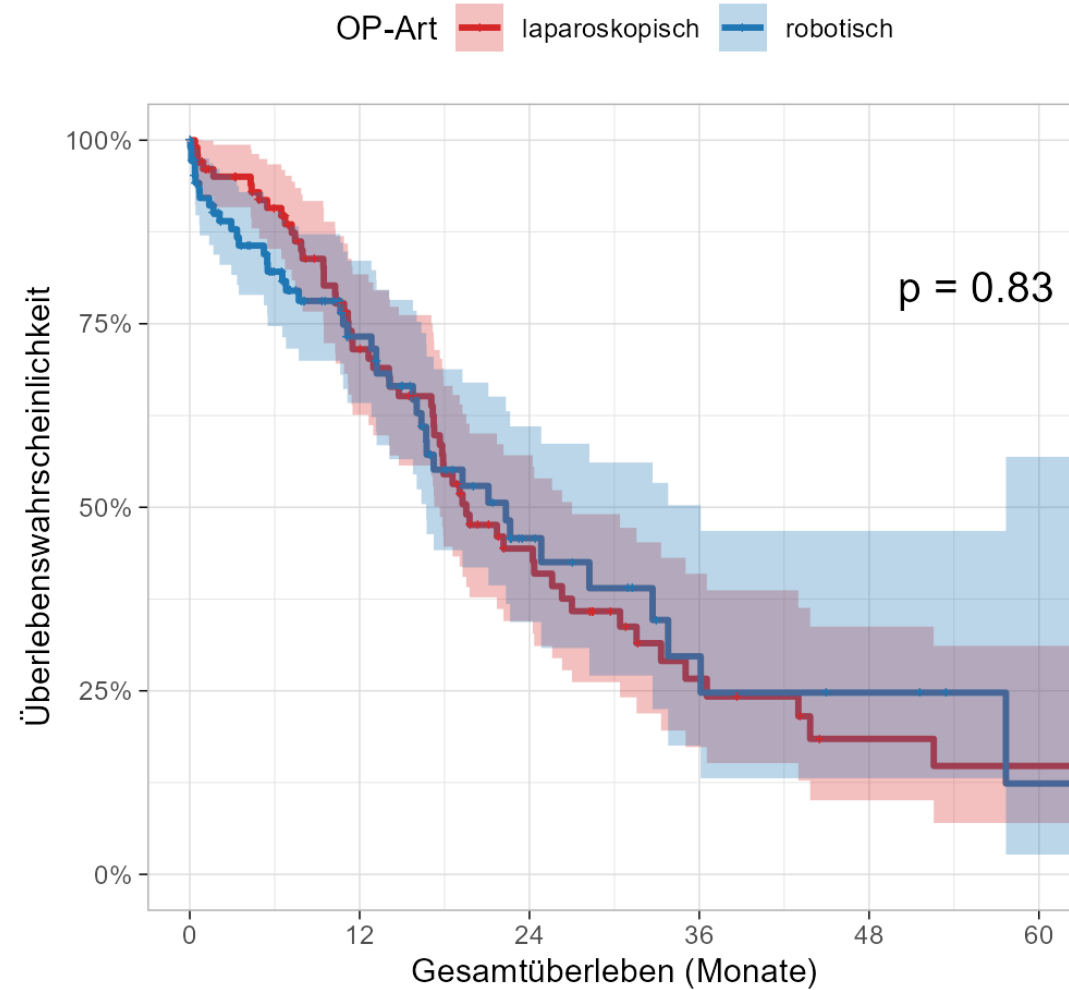
Pankreaslinksresektion

Lokale Rezidivrate



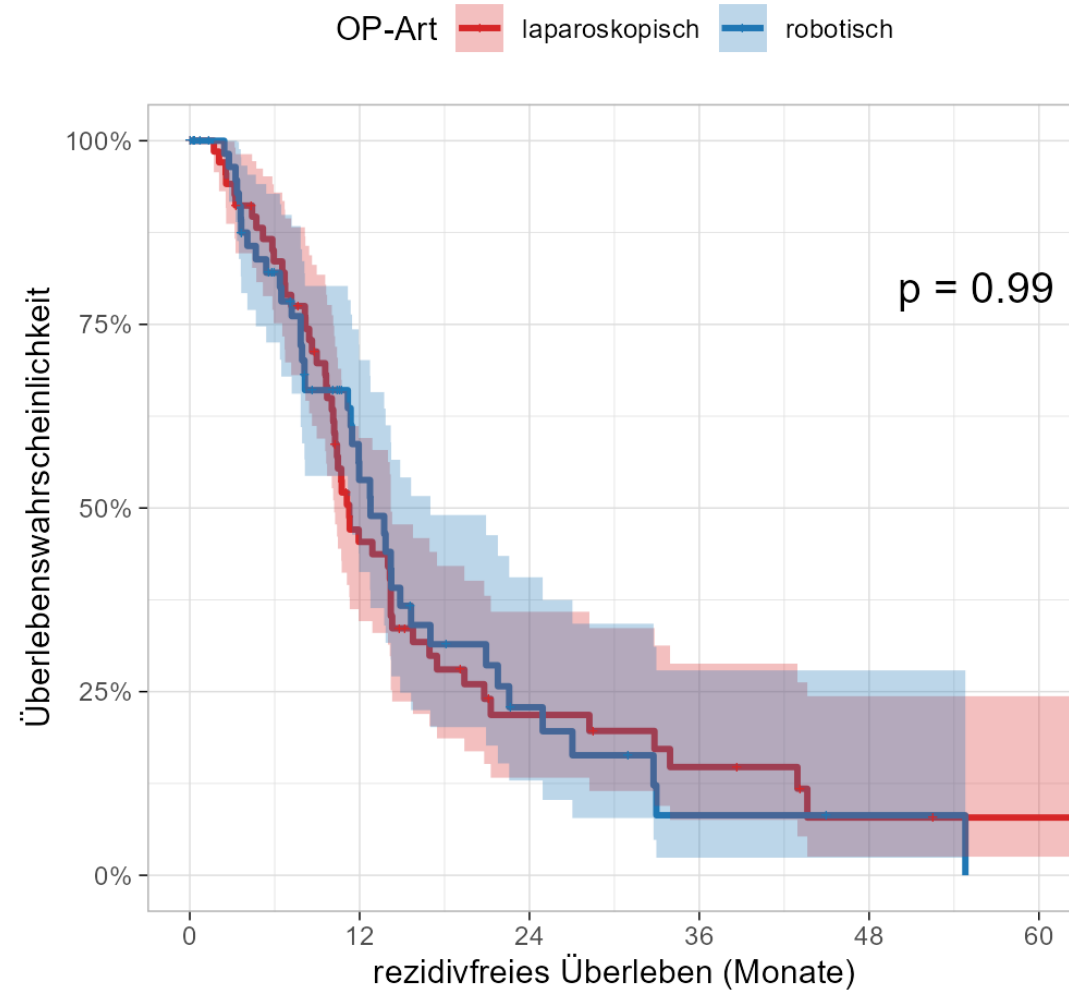
Pankreaslinksresektion

Gesamtüberleben



Pankreaslinksresektion

Rezidivfreies Überleben



Herzlichen Dank

Auswertungsteam

Dr. Thaer Abdalla
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Dr. Steffen Deichmann
PD Dr. Kim Honselmann
Prof. Dr. Richard Hummel
Prof. Dr. Tobias Keck

Universitätsklinikum Schleswig-Holstein,
Campus Lübeck

*Danke an
die....*

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Prof. Dr. Monika Klinikhammer-Schalke
Kees Kleihues-vanTol

Arbeitsgemeinschaft Deutscher Tumorzentren, Berlin

& alle teilnehmenden Krebsregister !