(10) 消化系及甲狀腺手術之新趨勢

The State of the Art in Digestive and Thyroid Surgery

時 間:113年6月22日(星期六)08:30~12:00

地 點:臺北榮民總醫院 中正樓 10 樓一般外科會議室

08:20-08:30	Opening Remarks	一般外科 王心儀主任 Shin-E Wang
	座長:陳世欽 醫師 (Shih-Chin Chen)	
08:30-09:15	局部晚期胰臟癌多型性治療經驗分享 Case Sharing in Multimodality Treatment for Locally-Advanced Pancreatic Head Cancer	石柏軒醫師 Bor-Shiuan Shyr
	長:減重及代謝手術中心 方文良 主任 (Wen-Liang Fang)	
09:15-10:00	減重手術的發展及當前趨勢 The Development and Current Trends of Bariatric Surgery	宮慶雲醫師 Ching-Yun Kung
10:00-10:30	Coffee Break	
	座長:甲狀腺醫學中心 陳瑞裕 主任 (Jui-Yu Chen)	
10:30-11:15	內視鏡甲狀腺手術之優勢及限制 Benefits and Limitations of Endoscopic Thyroid Surgery	黎瀚棻醫師 Hon-Fan Lai
	座長:雷浩然 醫師 (Hao-Jan Lei)	
11:15-12:00	螢光顯影於肝臟手術之應用 Fluorescence Imaging in Liver Surgery	周書正醫師 Shu-Cheng Chou

Case sharing in multimodality treatment for locally-advanced pancreatic head cancer

局部晚期胰臟癌多型性治療經驗分享

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Background

Locally advanced pancreatic head cancer were considered as unresectable disease; however, with the adaptation of neoadjuvant treatment with advanced modern radiotherapy technique, more-and-more studies demonstrated promising outcomes of such patients after receiving conversion surgical treatment. We hereby present our humble experience of the first case of initially unresectable locally advanced pancreatic head cancer treated with conversion pancreaticoduodenectomy surgery after neoadjuvant chemotherapy and carbon-ion radiotherapy.

Presentation of case

A 74-year-old man was initially diagnosed with locally advanced pancreatic head-to-uncinate process ductal adenocarcinoma with tumor encasing SMV/main portal vein and obliteration of splenic artery, common hepatic artery, and SMA (cT4N0M0). After receiving 8 weeks of neoadjuvant chemotherapy Gemcitabine (1000mg/m2 on day 1, 8, and 15 in 4 weeks cycle) followed by 12 fractions of concurrent carbon-ion radiotherapy, a dramatic decline in serum tumor marker CA 19-9 from 219 U/mL to 50.4 U/mL was observed. He then underwent another 7 weeks of maintenance chemotherapy with SLOG regimen (oral S-1, leucovorin, oxaliplatin, and gemcitabine) followed by conversion pancreaticoduodenectomy surgery with successful R0 resection. Narrowing of portal vein with massive ascites and micro liver abscess were observed after surgery, which were successfully treated by percutaneous portal vein stenting and intravenous antibiotic therapy.

Conclusion

This is our first case experience of initially locally advanced unresectable pancreatic head cancer successfully treated with conversion surgery after neoadjuvant chemotherapy and carbon-ion radiotherapy.

The development and current trends of bariatric surgery

减重手術的發展及當前趨勢

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For nearly two decades, bariatric surgery has stood as the cornerstone in treating morbid obesity, backed by compelling evidence from randomized controlled trials affirming its effectiveness and safety.

Currently, laparoscopic sleeve gastrectomy (LSG) is the most commonly performed bariatric surgery, followed by Roux-en-Y gastric bypass (RYGB). However, in the past 10 years, more and more treatment options have been emerging, including glucagon-like peptide-1 receptor agonist (GLP1-RA), endoscopic intervention and newly developed bariatric surgical procedures. The development of those new weapons for obesity makes it possible for us to provide personalized treatment according to the condition of each patient.

Hereby, the development of bariatric surgery will be introduced, and further trends will be discussed, with the goal of providing tailored treatment options for morbid obese patients.

Benefits and limitations of endoscopic thyroid surgery

內視鏡甲狀腺手術之優勢及限制

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Endoscopic thyroid surgery has revolutionized the field of thyroid surgery, offering patients an alternative to traditional open procedures. Two popular techniques, Transoral Endoscopic Thyroidectomy Vestibular Approach (TOETVA) and Bilateral Axillo-Breast Approach (BABA), have gained prominence for their efficacy and cosmetic outcomes. This review compares the benefits and limitations of TOETVA and BABA, highlighting their unique characteristics and considerations.

TOETVA is a scarless thyroidectomy technique performed through the oral vestibule, minimizing visible neck scarring. It offers excellent cosmetic outcomes, particularly appealing to young patients or those with cosmetic concerns. Despite its advantages, TOETVA is not suitable for all patients. The technique is limited to select cases with specific criteria, such as small thyroid nodules. Patients with a history of neck surgery or significant thyroiditis may also be poor candidates for TOETVA due to increased technical difficulty and risk of complications.

On the other hand, BABA is a bilateral axillo-breast approach that offers a more versatile approach to thyroidectomy. BABA provides excellent exposure of the superior pole of thyroid gland, allowing for safe dissection and precise identification of critical structures. However, BABA is not without limitations. The technique requires incisions in the axilla and breast, which may result in visible scars, although they are generally well-concealed. BABA also has a longer learning curve compared to TOETVA, requiring specialized training and experience to master.

In conclusion, both TOETVA and BABA offer distinct advantages and limitations in the field of endoscopic thyroid surgery. The choice between TOETVA and BABA depends on various factors, including patient suitability and surgical expertise. Further research and experience are needed to refine these techniques and optimize outcomes for patients undergoing endoscopic thyroid surgery.

Fluorescence imaging in liver surgery

螢光顯影於肝臟手術之應用

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Intraoperative fluorescence imaging has become used widely for real-time visualization of biological structures and assessment of blood perfusion. In hepatobiliary surgery, fluorescence imaging using indocyanine green can be applied in the following applications.

Fluorescence cholangiography: fluorescence images of the extrahepatic bile ducts can be obtained by intrabiliary injection of ICG solution (0.025 mg/mL) or preoperative intravenous injection (IV) of ICG (2.5 mg). The latter technique begins to be used worldwide for confirmation of the bile duct

Identification of hepatic tumors: IV-injected ICG (0.5 mg/kg) accumulates in hepatocellular carcinoma tissues and in non-cancerous hepatic parenchyma surrounding liver metastasis, which can be used for intraoperative identification of subcapsular hepatic tumors by fluorescence imaging.

Hepatic segmentation: ICG solution (0.25 mg in 5 mL solution) is injected into a tumor-bearing portal branch under ultrasound guidance (positive staining technique). ICG can also be administered intravenously following closure of a corresponding portal pedicle (negative staining technique). These techniques enable long-lasting delineations of segmental boundaries throughout hepatectomy procedures because ICG retains in hepatocytes for more than 5 hours.

These techniques will develop into an indispensable intraoperative navigation tool, which may enhance accuracy of hepatobiliary surgery especially in the minimally invasive setting.