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PERSONALIZATION OF SURGICAL TACTICS FOR THE TREATMENT OF PATIENTS WITH NON-RESECTABLE PANCREATIC HEAD CANCER

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Due to the late diagnosis, up to 80% of patients with cancer of the head of the pancreas undergo only palliative surgical treatment in order to eliminate complications: obstructive jaundice and duodenal stenosis by a tumor through hepaticojejunostomy surgery or transpapillary prosthetics of the common bile duct with self-expanding metal stents (SEMS)[1]. Disadvantages of open operations are a high frequency of postoperative complications and mortality, and transpapillary stenting – obstruction of up to 40% of stents 6-8 years after their implantation [2]. When using modern polychemotherapy, the survival rate of patients exceeds a year, when the drainage function of stents is impaired, and surgical shunts function without complications [3,4]. Therefore, it is relevant to personalize the choice of treatment tactics for patients.

The purpose of the study was to improve the results of palliative surgical treatment of patients with unresectable cancer of the head of the pancreas by improving the choice of tactics and techniques of surgical interventions.

Materials and methods. In a randomized prospective study, the results of correction of obstructive jaundice by Roux-en- Y «end-to-side» hepaticojejunostomy with prophylactic gastrojejunostomy (main group, 53 patients) or transpapillary prosthesis of the common bile duct of the SEMS (comparison group, 54 patients) were analyzed. The impact of multiple organ dysfunction and the Karnofsky index on the choice of patient treatment tactics, on the immediate and long-term results and the quality of life of patients according to the EORTC QLQ-C30 V.3 and EORTC QLQ-PAN26 questionnaires was evaluated.

Results. Analysis of the results of surgery in both groups during the late and remote postoperative period (from 4 to 11 months) revealed that in patients of the main group, the biliodigestive and gastrodigestive bypasses functioned without incidents, for the remainder of their lives. However, in 6 (11.1%) patients after stenting of the biliary system using SEMS, in the period from 8 to 11 months after stenting, recurrences of jaundice and acute cholangitis were observed (according to the TG18 criteria). During the treatment of four of them, we performed repeated endoscopic stenting of the biliary system, in two cases the health condition was stabilized by endoscopic recovery of stents and antibiotic therapy, regarding the sensitivity of the bile microflora to antibiotics. In other 19 patients, in the period from 8 to 11 months after surgery, recurrent pain in the right hypochondrium with subfibrillation, tachycardia, loss of appetite, skin itching, relapsing jaundice with subicteric sclera were observed (hyperbilirubinemia ranged from 40.51 to 58, 3 μmol /l). Alkaline phosphatase activity increased by 26.8-33.67%, and ultrasound visualized an increase in the size of the liver, moderately enlarged, deformed intrahepatic bile ducts with thickened walls, which together with SEMS visualization corresponded to the diagnostic criteria of recurrent cholangitis [20, 21]. Intensive corrective therapy, antibiotic therapy, and endoscopic stent disinfection provided a positive, albeit short-term, effect (metastatic liver damage progressed). In 4 (7.4%) patients from the study group, the course of the disease was complicated by nausea, vomiting, feeling of heaviness in the epigastrium, and the progression of cachexia. According to the results of X-ray and fibrogastroduodenoscopy, the patients were diagnosed with stenosis of the duodenum due to a tumor of the pancreatic head. This complication was eliminated by intestinal stenting with duodenal SEMS. The use of SEMS for internal drainage of the biliary system in comparison with open double bypass operations reduces the frequency of postoperative complications by 29.9% ($\chi 2$=13.7, 95% CI 14.38-44.08, p=0.0002), and mortality by 7.5% ($\chi 2$=4.16, 95% CI - 0.05-17.79, p=0.04). However, the course of the remote postoperative period (8-11 months) in 11.1% of cases is complicated by acute, in 37.1% - recurrent cholangitis, in 7.4% of cases obstructive duodenal obstruction develops, which worsens the quality of life of patients and requires repeated hospitalization and reconstructive interventions.

Conclusions. The choice of treatment tactics for patients should be chosen depending on the terms of the predicted survival, taking into account the values of the Karnofsky scale. If the prognosis of survival is less than 5 months (Karnofsky index <80), it is advisable to perform prosthetics of the common bile duct of the SEMS, if the prognosis of survival is more than 8 months (Karnofsky index >80), it is advisable to perform surgical operations of double biliodigestive and prophylactic gastrodigestive bypass. When diagnosing patients with multiorgan dysfunction (hepato-renal and hemorrhagic syndromes) and cholangitis, surgical correction of obstructive jaundice should be carried out in two stages: at the first stage, endoscopic stenting of the common bile duct with a plastic stent and drug correction using intensive therapy methods for homeostatic disorders, at the second stage - surgical treatment.

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