

because of inability to achieve preoperative confirmation of cancer, while two patients were considered unfit for surgery. Five patients were receiving neoadjuvant treatment at the time of the analysis and two died before any treatment. Forty-three borderline resectable patients had neoadjuvant treatment. Nine of these eventually underwent attempted resection. Three were unresectable at laparotomy. Six (14%) underwent pancreatic resection. One patient required resection of the portal vein. All the resected specimens had clear margins, 3 (50%) had minimal or no histological response, 2 had moderate and 1 complete response.

Conclusions: Neoadjuvant therapy was safe and successfully administered in 94% of cases. However, a minority of treated patients were considered suitable for potential resection. Thus a neoadjuvant treatment strategy may be a useful selection tool to maximise surgical efficacy and prevent non-therapeutic surgeries. Further studies to investigate the effectiveness of neoadjuvant treatment are warranted.

PANCREAS CANCER 0746

BLOOD SUPPLY OF THE DISTAL PART OF THE PANCREAS – A NEW CLASSIFICATION SYSTEM

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Aims: The sophisticated surgical approaches and diagnostic methods need detailed knowledge of the arterial variations. Data on the upper abdominal arterial variations from different countries display highly variable nomenclatures and statistics. Thus we aimed to perform a detailed analysis of the blood supply of the distal part of the pancreas.

Methods: We examined 59 corrosion casts of human abdominal organ complexes. Resin mixture was injected through the abdominal aorta and after its hardening the parenchyma was corroded. Digital photographs, CT images were taken followed by 3D reconstruction.

Results: The dorsal pancreatic artery (DPA) arose from the splenic artery in 36 cases, from the right gastric artery (RGaA) in 3 cases, from the right hepatic artery (RHA) in 1 case, from the coeliac trunk (TC) in 2 casts, from the common hepatic artery (CHA) in 5 cases; the DPA was absent in 12 casts. The transverse pancreatic artery (TPA) was the left branch of the DPA in 31 cases, it arose from the RGaA in 9 casts, from the superior mesenteric artery (SMA) in 8 casts, from the RHA in 1 case, from the middle colic artery (MCA) in 1 case; it was absent in 9 cases. We also analysed the prepancreatic arcade (PPA) in respect of the connecting vessels and diameters. A new classification system was worked out on the blood supply of the distal part of the pancreas. The distal pancreas supplying arterial patterns were classified into 10 categories based on the variations of DPA, TPA, and PPA.

Conclusions: We made a detailed description on the pancreatic blood supply distal from the neck. A new, more clear-cut classification system was set up that may eliminate the confusing mismatching nomenclatures and therefore it may come in useful for the surgeons, radiologists and pathologists.

PANCREAS CANCER 0777

ASSESSMENT OF A SAFE INTERVAL BETWEEN RADIOLOGICAL STAGING AND SURGICAL RESECTION FOR RESECTABLE PANCREATIC MALIGNANCY

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Aims: To assess the safest interval between pre-operative radiological staging of the abdomen and date of surgery in patients undergoing resection for pancreatic ductal adenocarcinoma (PDA) and cholangiocarcinoma of distal common bile duct (CC), in relation to intra-operative findings of local disease progression, resulting in abandoned curative procedures.

Methods: Data were retrospectively analysed from a single centre prospectively collected database. Patients with histologically confirmed PDA or CC, undergoing surgery with curative intent between January 2008 and October 2014, were included. Pre-operative staging was determined by phase specific CT Thorax-Abdomen-Pelvis or MRI abdomen with CT Thorax. Imaging were reported by HPB radiologists and reviewed by regional HPB MDT. Intra-operative findings of disease progression with locally advanced tumour (LAT) (unresectable vascular encasement) or presence of intra-abdominal metastasis were responsible for abandoned procedures. Logistic regression analysis was used to assess the influence of the interval between last scan and surgery on odds of having abandoned procedure.

Results: 174 patients underwent surgery, 133 (76.4%) had PDA. Curative procedures were abandoned in 45 cases (25.9%). In 88.9% (40) there was PDA. 93.3% of abandoned procedures were due to LAT. There was no significant difference in time interval between last radiological staging and surgery in the abandoned group versus resection group (Median 33 vs 28 days; $p = 0.40$).

Conclusions: Higher rate of abandoned procedures was seen in patients with PDA (30.1% vs 12.2%, $p = 0.025$). LAT was responsible for abandoned procedure in 92.5% of PDA and in 100% of CC. There was no evidence that increasing the interval between last radiological staging and surgery would increase the odd of an abandoned procedure ($OR = 1.01$, 95%CI, $p = 0.14$). Plot curve suggested that up to 60 days the probability of having an abandoned procedure remains nearly unchanged. A non statistically significant upward trend of the curve was seen from day sixty onwards.

PANCREAS CANCER 0787

STAGING LAPAROSCOPY FOR PERIAMPULLARY CARCINOMA AT A TERTIARY PANCREATOBILIARY CENTRE

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Aims: Despite thorough pre-operative radiological staging a significant proportion of patients with periampullary cancers