

# Laparoscopic pancreatic surgery in a single setting

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## ABSTRACT

Over the last decade, laparoscopic surgery for benign and malignant pancreatic tumours has progressively gained favour and is now being used in many centres. Some studies show that this method is as good as or better than open surgery, although randomised data is needed to determine the outcome. By pooling high-quality published material, we want to give a thorough review of the state of the art in laparoscopic pancreatic surgery in this Review. The benefits, restrictions, oncological effectiveness, learning curve, and most recent advancements are all highlighted. Although the focus is on the laparoscopic Whipple technique and laparoscopic distal pancreatectomy for both benign and malignant illness, robot-assisted surgery is also discussed. Surgical and oncological results, as well as quality of life and cost-effectiveness of laparoscopic pancreatic surgery, are examined. We've also added decision-aid algorithms based on research and our own experience, which might help you decide whether to have a laparoscopic or open operation. Solid malignancies of the kidney, colon, adrenal glands, and

prostate are now regularly treated via laparoscopic (lap) organ resection. Because of the operational intricacy and potential for complications, surgeons have been cautious to embrace minimally invasive methods to the pancreas. The vast majority of available papers on lap pancreatectomy are single-center research with fewer than 20 patients described. Larger cases proving the safety and effectiveness of lap tumour enucleation and lap left pancreatectomy have just recently appeared. Understanding the impact of the lap approach to pancreatectomy on cancer prognosis is critical since neoplastic illness is the most prevalent reason for pancreatic resection. Adequacy of resection as determined by margin status and nodal evaluation must be examined in addition to concerns about port-site tumour recurrence and tumour spread owing to lap manipulation in the presence of pneumoperitoneum. The development and current state-of-the-art of lap pancreatic surgery for cancer are discussed in this study. Existing data on open and lap pancreatic resections is reviewed, with a focus on pancreatic ductal adenocarcinoma. Future advancements in the field of lap pancreatic surgery are expected.

**Key Words:** *Pancreatectomy; Pneumoperitoneum; Pancreatic resections*

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## INTRODUCTION

In 1992, the first laparoscopic resections for pancreatic neoplasms were performed. Throughout the next decade, it was frequently demonstrated that laparoscopic resections of pancreatic neoplasms were practical, safe, and could be conducted with appropriate resection margins<sup>2-7</sup>. In terms of short-term outcomes, laparoscopy has been found to be superior to open distal pancreatectomy. Too far, the majority of investigations have been single-institution series with small patient populations, mainly involving resections of minor or benign lesions. The role of laparoscopic resections for malignant neoplasms is still up for discussion. In 1997, the laparoscopic and surgery for lesions in the body and tail of the pancreas was established at Rikshospitalet University Hospital, a tertiary referral hospital. Regardless of size or suspected underlying disease, laparoscopic resection has become the preferred approach for removing lesions in the body and tail of the pancreas. The goal of this study was to look at the safety and feasibility of laparoscopic pancreatic surgery with the goal of

systemic inflammatory response syndrome (SIRS). Advances in interventional radiological methods have made it possible to avoid or delay surgical intervention. Surgery has been used seldom thanks to a multidisciplinary team approach (surgery, radiology, gastrointestinal, and critical care). The surgical method for pancreatic necrosectomy (removal of a sequestrum of clearly recognisable necrotic tissue that can be readily separated from surrounding healthy tissue during surgery) has been standardised. Furthermore, it is now known that the best surgical scheduling is 2 to 3 weeks following the beginning of pancreatitis to allow a sequestrum to develop, avoiding the significant morbidity and mortality associated with early pancreatic resections.

## THE TUMOR'S LOCALIZATION

Imaging methods are utilised to confirm and pinpoint the existence of a single or many insulinomas if abnormally high insulin levels are detected. Because the position of the insulinoma in the pancreas, its number, and its proximity to

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