Question & Answer Summary		
Topic - Webinar 1 - Pancreas		
Question Details		
	Question	Answer(s)
1	Dimitri Dorcaratto from Valencia. Great talk, thank you. Based on the current evidence would you include all your RESECTABLE patients in a Neoadjuvant protocol or you would select patients based on tumour size, lymph nodes or CA 19-9?	Good question, although I am sure this is the future at the present I do not treat my resectable patients with neoadjuvant tx
2	For the borderline resectable patient, all patients get drained and a metal stent. Are brushing sufficient or would the trend be toward EUS and core tissue prior to neoadjuvant therapy. Imraan Sardiwalla from Pretoria	If brushing citology is confirmatory I don't think a EUS guided be would be required
3	thank you Kito for excellent presentation. For your borderline cases, except CT triple phase , EUS and PET scan, are you include laparoscopy for all cases?	Hi Pavlos, yes I tend to do a staging lap in these patients as it can change management in approximately in 10/15% of cases
4	Kito, thank you very much for great presentation. What do you suggest for NA, FOLDIRINOX or CHRadiatiation	Sequential, chemotherapy with Folfirinox followed by chemo DXT. Similar protocol to MGH as I presented the slide from their study.
5	Do u routinely resect the mesopancreas	Yes always
6	any limit of ischemic time limit for venous and arterial reconst .?	well, not really, portal vein is usually not a big issue (from our Pringle experiences), but aim for less than 20 min, arterial depends if their is also sufficient backflow, but personal aim is 20min or better 15. To get that fast, be ready for immediate reconstruction, be prepared, get stitches ready and check out there is no tension.
7	Thank you Dr Stättner. Do you reconstruct always splenic vein when the confluence is affected or not? Do you base your decision on IMV drain in splenic or SMV?	thanks for your question, I always try to dissect as much as I can to keep length, IMV is certainly important, but you need to keep in mind, that patients that have an obstruction are used to this and have collaterals. What you do is put a clamp on it and watch out
8	If disease is stable on chemo (neoadjuvant/palliative) but locally advanced what you always explore, if not what criteria would you use to define those you would not offer exploration.	With LAPC is always a bit more tricky and I tend to wait a bit longer after the end of the neo-adjuvant tx. But still they can be explored
9	Thankyou for your excellent talks. To Prof Stättner, when you say "take the drains out as early as possible" when is that and what principles do you follow. Is it possible to follow an ERAS protocol in such major resections and if so what does that entail please? Many thanks.	we measure amylase via drains and serum Il-6 and serum lipase on day 1 and 3, if they are negative, we take it out. See our recent paper in World J Surgery2020 Sep 8, open access
10	First. Both excellent talks. Thank you very much. Second, a question: For drains management after Whipple procedure, do you use amylase in drains in order to take it out?	yes, day 1 and day 5
11	Great webinar, congratulations. I have 3 questions. First, do you clamp SMA during vein reconstruction? Is it always necessary? Second, do you use any special anticoagulation protocols for cases with vascular reconstructions? And the last one, what is your approach to splenic vein reconstruction when SMV/SV confluence needs to be resected. Thank you.	thanks for your questions. I never clamp the SMA, I add heparin before I clamp and put patients on heparin syringe for 48h (as thrombosis is worse than 1-2units or blood splenic vein is tied off
12	Pablo Beltran from Seville, Spain. Congratulation for the speakers. Prof. Fusai, you said you operate patients after neoadjuvant in case there was no radiological response to check if the tumour is resectable. Can you tell us if that strategy has decrease your resection rate? Thanks.	Yes of course as some patients who are explored cannot be resected. Probably around 20%.
13	Thank you very much for the wonderful presentations. this question is for Prof Kito Fusai, Do you use FAPI PET for the evaluation of borderline patients? and what do you think about the growing role of this unique technique?	I am afraid I do not use this investigation modality but we do an FDG PET scan in all these patients
14	Do you perform EUS and biopsy/cytology in all patients or in only those borderline.	only if imaging is not clear or preop chemo is planned or if patient I in a trial, in clearly resectable cases with typical imaging we do not perform it
15	Raffaele De Luca From Bari to both of speakers . When you perform arterial resection in case head cancer do you extended the resection to total pancreatectomy. Thanks a lot	Yes
16	Hi Dr Stättner. When doing venous reconstruction after resection for malignancy, do you use autologous venous grafts like the left renal vein or internal jugular or do you use synthetics grafts?	Well, in around 40 PV resections I only used 1 saphenous vein graft (from right groin) and one cadaveric donor graft and 1 peritoneal patch (as first described by Safi Dokmak from Paris). In all other cases I did an end to end reconstruction, longest interval was 6 cm. (Stä)
17	What is your opinion on irreversible electroporation after neoadjuvant treatment in initially SMA involvement and good response on neoadjuvant treatment but still with SMA involvement >180º?	I would not recommend it. Most of the experience is in the palliative setting
18	In which cases do resect at same time of DP with or without vascular reconstruction an isolate hepatic metastasis?	same as below
19	In which cases do resect at same time of DP with or without vascular reconstruction an isolate hepatic metastasis? Raul Oleas from HPB cancer centre of Ecuador	Very controversial, I have not done it.
20	Thanks for nice presentations. Concerning venous resection - if you ligate splenic vein, do you also ligate splenic artery?	No, just the splenic vein
21	A. Marichez - CHU Bordeaux, France. Thanks to both of your for your presentations. My question is the following : After venous reconstruction, do you systematically introduce curative anticoagulation ? If yes, for how long time ? Thank you	No I don't except for interposition autologous grafts