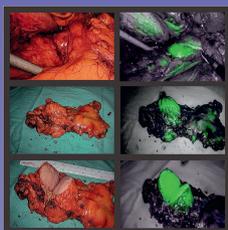
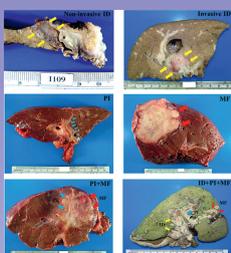


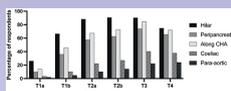
Highlights in this issue



Rompianesi *et al.*, p. 1829



Sa-ngaimwibool *et al.*, p. 1950



Balakrishnan *et al.*, p. 2009

This issue of *HBP*, covers a wide spectrum of HPB surgery; however, I'd like to draw your attention to four papers that focus on important and controversial topics in the literature.

How to manage patients planned for laparoscopic cholecystectomy with an intermediate risk of bile duct stones: results from a RCT

The first paper is a multicentre RCT carried out in Switzerland by *Staubli and colleagues*. The authors compared the efficacy of intraoperative cholangiography (IOC) to magnetic resonance cholangiopancreatography (MRCP) in patients with an intermediate risk of common bile duct stones (CBDS). Due to the lack of level 1 evidence on this topic, current guidelines do not give clear recommendations on how to approach patients planned for laparoscopic cholecystectomy with an intermediate risk of CBDS. The RCT by SM Staubli *et al.* included 122 patients with elevated bilirubin and/or elevation of two of the following serum parameters: AST, ALT, GGT, AP and/or dilated bile ducts on USS (>10 mm). Patients were either scheduled for laparoscopic cholecystectomy and IOC (in the case of positive findings, an ERCP was scheduled after surgery) or to MRCP followed by a laparoscopic cholecystectomy. The authors found that the two groups did not show significant differences in median length of stay (4 days), intraoperative time of the laparoscopic cholecystectomy, post-operative complications or costs. However, IOC presented a significantly higher diagnostic yield than MRCP. Therefore, it is still unclear whether or not an MRCP should be performed in patients with an intermediary risk of CBDS, as IOC may be an adequate alternative. The SUNFLOWER trial, which is currently recruiting patients with low and intermediate risk of CBDS to MRCP or expectant management before laparoscopic cholecystectomy, is likely to provide additional information on this topic.

Complications after arterial resection and reconstruction in patients with locally advanced pancreatic cancers: The Mayo experience

Alva-Ruiz and colleagues examined patients with locally advanced pancreatic cancers who underwent a pancreatectomy with concomitant en bloc arterial resection and reconstruction. Currently, few institutions are performing high-volume hepatic artery resections and reconstruction, thus the reported incidence and consequences of graft or anastomotic occlusions after revascularisation are relatively unknown. The authors provide one of the largest single institution series (108 patients) on the subject, which examines the consequences and risk factors of hepatic artery occlusion after pancreatectomy for locally advanced pancreatic cancer. The reconstruction was performed by either interposition grafts (61%) or primary end-to-end anastomoses (39%). Complete arterial occlusion (CAO) was defined as 'early' or 'late' before/after 90 days, respectively. CAO was identified in 18% of the cohort. Interposition grafts were less likely to occlude in comparison with primary anastomosis, and arterial grafts were associated with the least risk of CAO compared to venous and synthetic conduits. No association between CAO and in-hospital anticoagulation dosing was found. Finally, occlusion-related mortality was significantly higher amongst patients with early versus late occlusion. Future studies examining predictive factors of arterial graft failure and how to decrease the rate of early CAO are warranted.

Enhanced recovery pathway after liver transplantation: is it feasible?

The introduction of an enhanced recovery pathway in transplantation is still scarce. *Hillingsø and colleagues* from Copenhagen University Hospital show that ERAS principles apply to and are safe in liver transplantation. The study illustrates the progressive implementation of an ERAS protocol from 2013 to 2019. A total of 334 patients were included, and results showed a significant reduction in length of stay from a median of 22.5 days to 14 days, which was associated with a reduction in the severity of complications and comprehensive complication index. Importantly, the 30-day re-admission rate remained stable at around 12%, with a mortality rate of 2% and one-year mortality or graft loss of less than 10%. In conclusion, ERAS principles were safely and successfully introduced in a national, single-centre liver transplantation programme. However, there remains room for future improvement regarding the pre-, intra- and post-operative management of patients requiring liver transplantation. This is undoubtedly an important area we should focus on.

Total pancreatectomy and islet cell autotransplantation: long-term results from a high-volume centre

Chronic pancreatitis is a life-altering disease whose traditional therapeutic approaches include narcotics, decompressive and resective procedures. Total pancreatectomy (TP) with intraportal islet autotransplantation (IAT) includes the removal of the entire pancreas and the transplantation of the patient's dissociated islets back into the portal system to decrease pain and mitigate the risk of diabetes. Several papers have reported the favourable outcomes associated with this approach; however, there is a paucity of data on the long-term outcomes (10 years). *Turner and colleagues* assessed 142 patients who had undergone TPIAT. They found that a) opioid independence was achieved and remained durable in most subjects; b) while insulin independence tended to decrease over time, with an increase in HbA1C, partial islet function persisted; c) chronic complications of longstanding diabetes began to appear after 10 years and d) quality of life dramatically improved, with continued improvement up to 10 years. Further research should focus on how to mitigate the attenuation of islet graft function and optimise outcomes following TPIAT.

Enjoy the reading!

Marcello Di Martino