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Editorial

Reducing distal pancreatectomy by posterolateral approach for splenectomy in the surgical management of ovarian cancer

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▸ See the article "Predictors of postoperative pancreatic fistula after splenectomy with or without distal pancreatectomy performed as a component of cytoreductive surgery for advanced ovarian cancer" in volume 33, e30.

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Extensive cytoreductive surgical procedures to minimize residual tumor is important in the surgical management of primary and recurrent ovarian cancer as well [1,2]. Each 10% increase in maximal cytoreduction increase 5.5% of median overall survival in primary ovarian cancer [1]. And each 10% of complete and optimal cytoreduction increased 8.97% and 7.04% of median overall survival in platinum-sensitive recurrent ovarian cancer [2]. Therefore, diverse surgical procedures, including resection of the rectosigmoid colon, diaphragmatic stripping and/or resection, or splenectomy are frequently required surgical procedures.

In this issue of *Journal of Gynecologic Oncology*, Nishikimi et al. [3] reported 94% (155/165) of women who underwent splenectomy have combined surgical procedures of distal pancreatectomy. Of the 155 women who underwent splenectomy, pathological tumor involvement of the pancreas was not identified in 23 (15%) women between April 2008 and March 2021 [3]. Even the needs of distal pancreatectomy among the advanced epithelial ovarian cancer were not depicted numerically, the requirement could be considered differently with the surgical approach to the splenic hilum based on the personal surgical experience. Fig. 1 in this article showed an anterior approach to the splenic hilum and distal pancreas. I prefer posterior approach to that area after 1) careful adhesiolysis and dissection of tumor between splenic capsule and diaphragm, 2) dissection of gastrosplenic, splenocolic, phrenicocolic, phrenicosplenic, and splenorenal ligament with identification of distal pancreas, and ligation of splenic artery and vein. With these surgical procedures, more distal pancreas could be preserved rather than surgical resection with anterior approach in the surgical management of ovarian cancer. Neoadjuvant chemotherapy has been increasingly introduced in the management of advanced epithelial ovarian cancer over time [4]. In case of exposure to neoadjuvant chemotherapy, the surgical dissection plane is attenuated, especially for an anterior surgical approach. Therefore, a posterior surgical approach should be strongly recommended to have more chance of preservation of the distal pancreas.

Amylase level in drain fluid at the postoperative day 3 is the predictor to identify postoperative pancreatic fistula with area under the curve, 0.77 using cut-off of 808 U/L [3]. The postoperative pancreatic fistula was identified in 12% of the patients (n=20) [3], which did not result in significant complications if the isolated surgical procedure without bowel

surgery was performed. However, in those cases with distal pancreatectomy, bowel surgery, and anastomosis, including resection of the rectosigmoid colon, is required frequently. The leaked pancreatic fluid could cause the leakage of the anastomotic site of the bowel, especially in the rectum which is directly related to rectal pressure during defecation. The interval from surgery to adjuvant chemotherapy is one of the prognostic factors in advanced epithelial ovarian cancer with complete cytoreduction [5]. Therefore, the balance between two issues, maximal cytoreductive effort and early initiation of adjuvant chemotherapy needs to be considered critically.

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