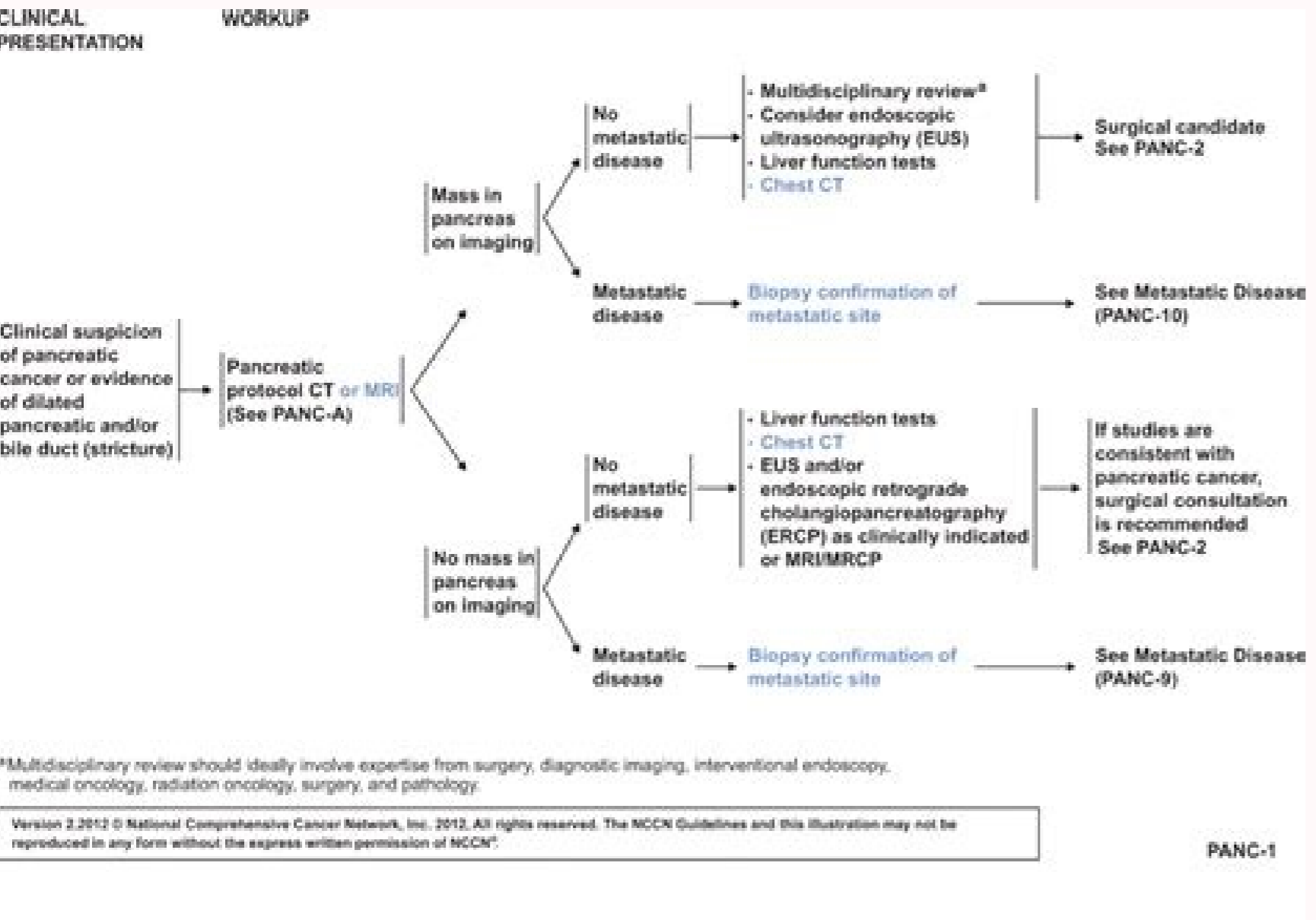
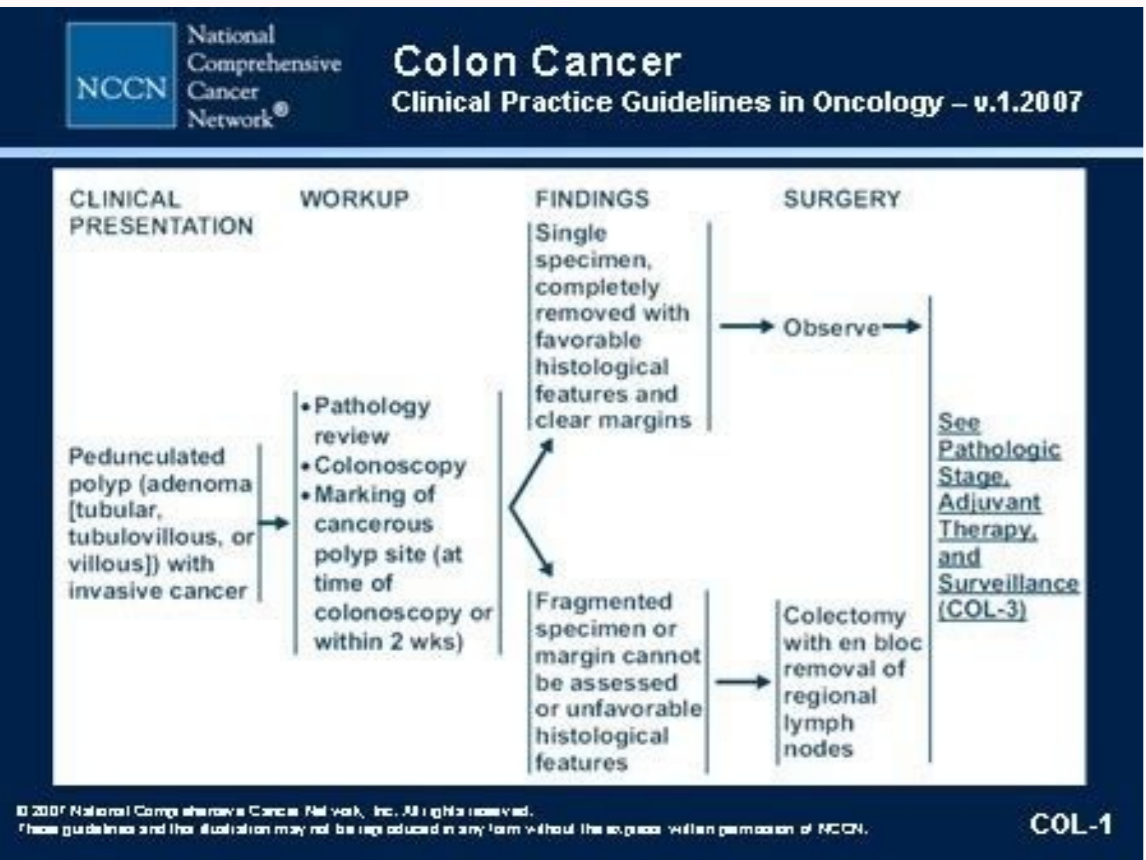
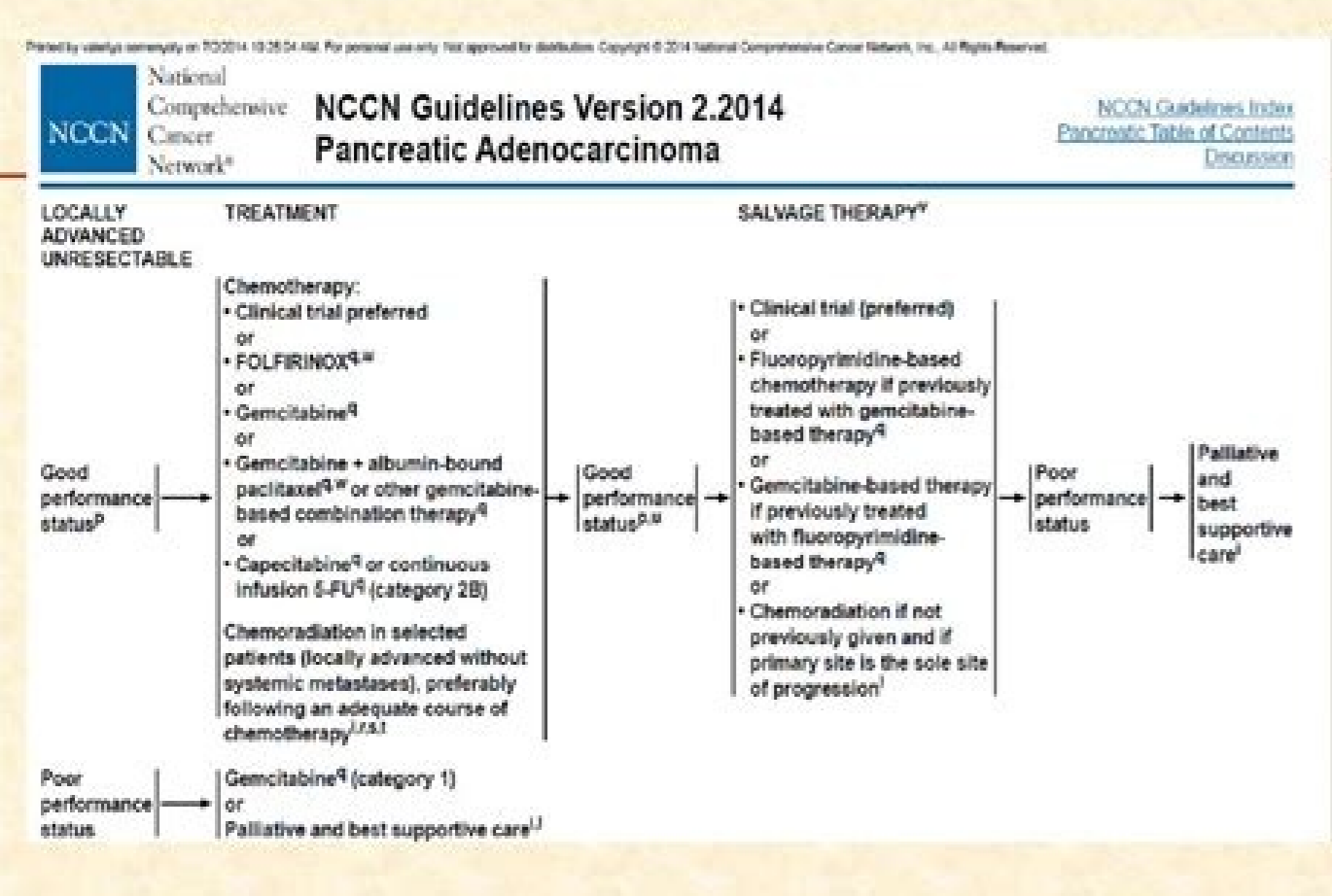


I'm not robot!



Staging MODALITIES

- According to 2011 NCCN guideline, CT scan primary mean for staging
 - Triphasic multidetector spiral(helical) dynamic contrast-enhanced CT with thin-slice, cross sectional imaging is recommended i.e. pancreas protocol CT scanning
- EUS 70-80 % accurate for correct staging/predicting resectability
- Staging Laparoscopy (with US 98 % accurate)
 - Some use it routinely in all patients with pancreatic cancer
 - Others, including NCCN 2011 guidelines, advise selective approach with any of following criteria:
 - CA 19-9 > 1000 U/mL or marked wt loss
 - Low volume ascites
 - Body/tail of pancreas tumor
 - Borderline resectable tumors/equivocal findings of metastasis
 - Size > 4 cm
 - CBD lymphadenopathy
 - Does not show vascular invasion or retroperitoneal invasion which makes apparently resectable tumor irresectable one

Table II. Values are the mean±SD. Relationships between clinicolaboratory features and subclass of stage IV colorectal carcinoma.

Variable	Stage IVa (M1a) (n=77)	Stage IVb (M1b) (n=92)	p-Value
Age (years)	67±11	67±11	0.926
Number of tumors	1.1±0.4	1.1±0.4	0.852
Maximum tumor size (mm)	59±22	58±22	0.860
WBC count (10 ³ /mm ³)	7.0±2.2	8.0±3.2	0.059
Neutrophil ratio (%)	67±9	68±10	0.197
Lymphocyte ratio (%)	24±8	22±8	0.143
Monocyte ratio (%)	6.6±2.2	7.2±2.4	0.184
Platelet count (10 ³ /mm ³)	29±11	33±12	0.230
CRP (mg/dl)	1.7±2.7	2.3±3.5	0.285
Albumin (g/dl)	3.5±0.5	3.3±0.7	0.037
CEA (ng/ml)	303±705	319±793	0.488
BMI (kg/m ²)	23±3	22±3	0.024
NLR	3.4±2.4	3.9±3.1	0.164
Operative time (min)	340±136	262±143	<0.001
Intraoperative bleeding (ml)	660±1474	456±701	0.038
Postoperative survival period (days)	636±577	518±588	0.073

BMI: Body mass index; CEA: carcinoembryonic antigen; CRP: C-reactive protein; NLR: neutrophil to lymphocyte ratio; WBC: white blood cell. Mann-Whitney U-test.

Nccn guidelines ampulla of vater cancer. Pancreatic cancer nccn guidelines. Oral cancer nccn guidelines. Hepatobiliary cancer nccn guidelines.

The National Comprehensive Cancer Network (NCCN) has released new guidelines for ampullary adenocarcinoma, a disease accounting for just 0.2% of all gastrointestinal malignancies.^{1,2} Physicians determine treatment for ampullary adenocarcinomas depending on whether the tumor histology is pancreatobiliary, intestinal, or mixed. E. Gabriela Chiorean, MD, colead of the NCCN Ampullary Adenocarcinoma committee and medical director of gastrointestinal medical oncology with Fred Hutchinson Cancer Center, said the NCCN wanted to help physicians make those treatment decisions and classify optimal local treatments. The ampulla of Vater region, or just "ampulla," is the crossroad of the intestinal, ductal pancreatic, and biliary epithelia.³ It has 4 parts in a narrow area of the ampulla, including tissue of the periampullary pancreas. "Because it's basically the nexus of between the biliary and pancreatic ducts with the small intestine, the ampulla it has a very complex histology," Chiorean said. Most ampullary adenocarcinomas are intestinal or pancreatobiliary. In 2019, German investigators published findings from a retrospective analysis of 170 patients with ampullary cancer who received pancreatic resection from 1999 to 2016. Fifty percent of patients harbored the pancreatobiliary subtype, 34.5% had intestinal disease, and 7.6% had mixed subtype.⁴ Survival analysis from that study showed a significantly worse 5-year overall survival (OS) rate for the pancreatobiliary subtype compared with intestinal at 27.5% vs 61%, respectively (P

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