
Implications of Arterial Variations in Pancreatoduodenectomy for Cancer

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Abstract: Pancreatoduodenectomy for cancer is a complex surgical procedure with significant morbidity and mortality. Technical aspects of this procedure typically comprise dissection of celiac trunk, the common and the proper hepatic arteries. The presence of hepatic arterial anomalies is not uncommon and influences surgical technique. An aberrant right hepatic artery (replaced or accessory) or a common hepatic artery originating from the superior mesenteric artery are present in nearly 13% of cases and usually run in contact with the posterior aspect of the head of the pancreas. These anomalous arteries are at risk of iatrogenic injury and tumor involvement. Iatrogenic vascular lesions can lead to bleeding and/or ischemic complications, such as anastomotic stenosis, hepatic abscess and liver failure. Also, vascular tumor involvement might require arterial resection and reconstruction. The presence of arterial variations should not affect the radicalness of pancreatic resection as the involvement of aberrant arteries does not seem to affect postoperative outcomes or overall survival. These vascular variations should be, preferably, recognized pre-operatively in order to define possible surgical strategies. Preoperative contrast enhanced computed tomography provides accurate arterial anatomy evaluation. Lastly, aberrant hepatic arteries require proper dissection and/or occasionally resection and reconstruction during pancreatoduodenectomy to achieve a safe resection with proper radicalness. Knowledge of arterial variations is crucial for pancreatic cancer surgery.

Keywords: Pancreatic Cancer, Pancreatoduodenectomy, Arterial Variations, Pancreatic Surgery

1. Introduction

Pancreatoduodenectomy (PD) is the main surgical technique for the treatment of periampullary tumors. [1] Despite technical advances in pancreatic surgery, PD remains a challenging procedure with mortality rates from 1% to 6%. [1–5] Some arterial variations can be of major surgical significance during PD for cancer. Recognition of such anomalies is of major importance to avoid iatrogenic vascular lesions with consequent bleeding or ischemia of structures or organs leading to possible anastomotic stenosis (such as

biliary or pancreatic anastomosis), hepatic abscess, or even liver failure. Additionally, tumor involvement of aberrant arteries might demand vascular resection and reconstruction. [6]

The main arterial variations presenting clinical implications in PD for cancer are those concerning liver arterial blood supply, i.e. abnormal hepatic arteries. [7, 8]

Knowledge of the range of arterial anomalies during PD prevents intraoperative and postoperative complications and allows the use of appropriate oncological surgical techniques, leading to better oncological results.

2. Pancreatoduodenectomy and Arterial Variations

Pancreatoduodenectomy was first described by Whipple *et al.* [9] in 1935. Despite several modern technical modifications, PD remains a complex procedure. Pancreatoduodenectomy comprises dissection of common and proper hepatic arteries and dissection and section of the gastroduodenal artery in its origin. Pancreatoduodenectomy for cancer usually includes lymphadenectomy of the common hepatic artery and celiac trunk. Also, pancreatic arterial branches from superior mesenteric artery are ligated and sectioned during retroportal pancreatic lamina section. [10, 11]

Following normal development, common hepatic artery arises from celiac trunk and it continues as the proper hepatic artery after giving origin to the gastroduodenal artery. The proper hepatic artery usually originates the right and the left hepatic arteries before reaching the hepatic parenchyma. The superior mesenteric artery usually provides branches to pancreatic head and middle gun. However, this regular arterial pattern is present in only 62% to 90% of patients. [12–16] Thus, anatomical arterial variations of the hepatic arterial system are quite frequent. The most used classification for these variations was that proposed by Hiatt

[17] in 1994, as described in Table 1.

Table 1. Hiatt classification of hepatic arterial supply.

Type	Description	Percent
1	Normal	75.7
2	Replaced or accessory LHA	9.7
3	Replaced or accessory RHA	10.6
4	Replaced or accessory RHA and replaced or accessory LHA	2.3
5	CHA from SMA	1.5
6	CHA from aorta	0.2

LHA, left hepatic artery. RHA, right hepatic artery. CHA, common hepatic artery. SMA, superior mesenteric artery.

The mains arterial variations with potential implications during a PD was investigated in a recent large study and prevalence of standard and aberrant patterns. [6] The presence of a right hepatic artery (replaced or accessory) or a common hepatic artery originating from the superior mesenteric artery were considered as the main variations requiring special caution or modifications during pancreatoduodenectomy. [6] In that study, anomalous right hepatic artery was found in 13% of cases with 6% having a replaced aberrant right hepatic artery (Figure 1).

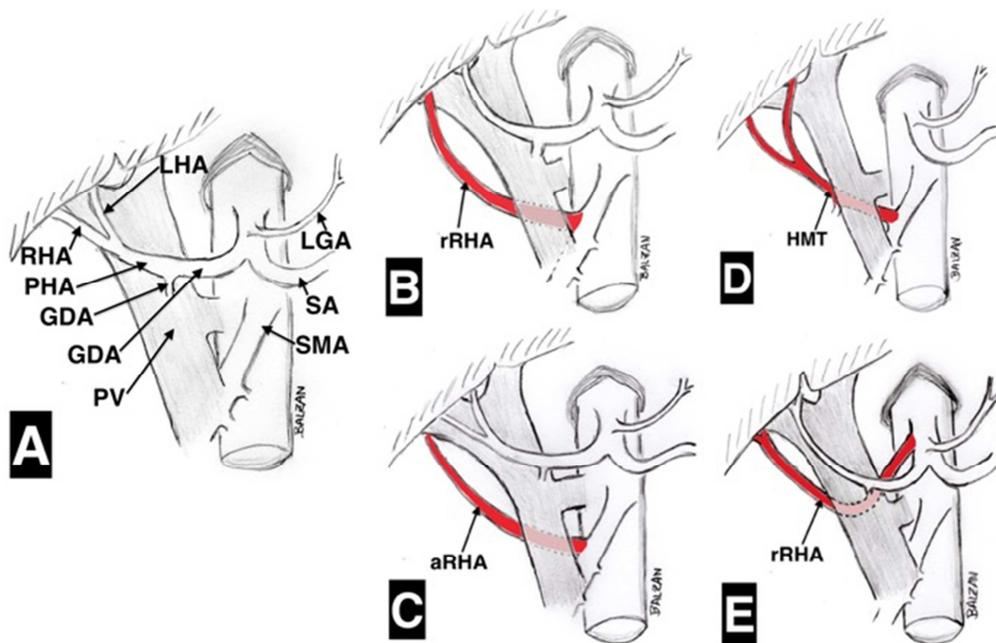


Figure 1. Schematic representation of hepatic arterial system variations with implications in pancreatoduodenectomy. A) standard arterial anatomy; B) replaced right hepatic artery from superior mesenteric artery (prevalence 6%); C) accessory right hepatic artery from superior mesenteric artery (prevalence 1%); D) right hepatic artery from hepatomesenteric trunk (prevalence 3.5%); E) replaced right hepatic artery from celiac trunk (prevalence 2.5%). Modified from Balzan *et al.* [6] LHA, left hepatic artery. RHA, right hepatic artery. PHA, proper hepatic artery. GDA, gastroduodenal artery. PV, portal vein. LGA, left gastric artery. SA, splenic artery. SMA, superior mesenteric artery. rRHA, replaced right hepatic artery. aRHA, accessory right hepatic artery. HMT, hepatomesenteric trunk.

An aberrant right hepatic artery typically runs upward behind the head of the pancreas and is often in contact with the posterior aspect of the pancreas and lateral and posterior aspect of the portal vein trunk. Rarely its course is prepancreatic. [18, 19]

All these abnormal arteries and its courses are accurately

recognizable in preoperative contrast enhanced computed tomography. Thus, cautious preoperative imaging evaluation allows adequate surgical strategies.

2.1. Vascular Injury of Abnormal Hepatic Arteries

Ligation of a hepatic artery may result in life-threatening

complications such as hepatic necrosis, liver abscesses, ischemic biliary injury, and anastomotic fistula. [20, 21] Thus, except in some cases of accessory vessels, ligation of aberrant hepatic arteries should be avoided.

A variant technique of PD that beginning with the dissection of the origin of the superior mesenteric artery above the left renal vein and section of the retroportal pancreatic lamina could be useful to a secure dissection of the superior mesenteric artery and safe identification of main arterial anatomic variations. [22–24] This approach could prevent lesions of anomalous arteries not identified preoperatively.

2.2. Tumoral Involvement of Anomalous Arteries

The radicality of PD for cancer is crucial. Dissection of an aberrant hepatic artery far from the pancreas is possible with no radicality compromising if the artery is not involved by the tumor. This is a technically demanding procedure but could avoid vascular reconstruction. Arterial resection and reconstruction may be necessary in case of tumor encasement or intra-pancreatic course of the anomalous hepatic artery. The presence of arterial variations should not affect the radicality of pancreatic resection and involvement of aberrant arteries seems does not affect postoperative outcomes or overall survival. [25–27] Despite it is not clear if the involvement of aberrant hepatic arteries has the same clinical impact than involvement of normal arteries, resection of a tumor involved anomalous right hepatic artery is acceptable. [8, 25, 28]

2.3. Arterial Reconstruction in Pancreatoduodenectomy for Cancer

Despite of most cases of PD for cancer does not require arterial resection, if an anomalous hepatic artery is found to be encased with tumor the usual option is resection and reconstruction. According to the length of vessel resection and its diameter, an end-to-end anastomosis is performed. Also, the distal segment can be anastomosed to other arteries, such as the sectioned gastroduodenal artery or even splenic artery. [29, 30] An alternative to reconstruction is to perform preoperative angiographic embolization of the artery to be ligated. This procedure should allow collateralization and prevent hepatic ischemia. [8, 31, 32]

3. Conclusion

Arterial anomalies, mainly of hepatic arteries, are not uncommon and can result in vascular involvement by pancreatic tumors and increase the risk of vascular injury during pancreatoduodenectomy. Tumor involvement of aberrant arteries around the pancreas can make pancreatoduodenectomy a procedure even more complex, especially if arterial resection and reconstruction are necessary. Thus, arterial variations may require a change in the surgical approach to achieve an adequate and safe resection. Precise preoperative knowledge of such anomalies

is helpful for proper surgical planning.

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