LYMPHADENECTOMY DURING ADRENAL SURGERY – AN ONGOING CHALLENGE, COULD WE DO BETTER?

Contact name: Puttergill, Brooke
Institution/company: Department of Endocrine Surgery, Churchill Cancer Centre, Oxford
Phone: 958536820
Country: United Kingdom
E-mail: brookeputtergill@hotmail.com
Type of communication: ORAL
Number Abstracs: 158
Area: 4. General topics on endocrine surgery: Adrenal.

B Puttergill Department of Endocrine Surgery, Churchill Cancer Centre, Oxford; Shahab Khan Department of Endocrine Surgery, Churchill Cancer Centre, Oxford; T Barnes Department of Endocrine Surgery, Churchill Cancer Centre, Oxford; R Mihai Department of Endocrine Surgery, Churchill Cancer Centre, Oxford

Abtract body (should contain maximum 300 words)
Aknowledgement. The authors are grateful to members of the ESES-ENSAT working group who provided anonymised data for ACC patients operated in their units. Background. Lymphadenectomy for adrenocortical carcinoma is associated with improved prognostication and outcome but its implementation in clinical practice remains challenging. Method. Historical histopathological reports were scrutinised. A prospective cohort study was setup to assess whether ICG fluorescence improves lymph node (LN) yield during adrenalectomy. Results. 35 patients with ACC operated had a mean tumour diameter of 11 cm (4-21cm), with lymphovascular invasion in 23 patients and resection margins assessed as clear (R0, n=25) or microscopically involved (R1, 10). LNs were identified in 15 patients (43%) with a median yield of two nodes (1-9) and 33% node positive rate. Out of 20 en-block multivisceral resections, seven had no LN identified. Similarly, analysis of 40 patients operated in six European units showed : six cases (15%) had a median LN yield of 2 (1-5). In a pilot study of five patients, ICG was injected intratumoural (n=4) and/or systemically (n=3) during right-sided (n=3) or left-sided (n=2), laparoscopic (n=2) or open (n=3). Imaging was done 10-30 minutes after ICG injection. No LNs were demonstrated along the IVC, renal veins nor in periadrenal tissue. Interestingly lymphatic channels were seen within the perirenal fat in two patients but none led to any identifiable LN. Conclusion. Despite aiming to perform adrenalectomy with wide resection margins and en-block resections, current surgical strategies in ACC fail to provide consistent lymphadenectomy results. There is a need to investigate ICG fluorescence adapted to adrenal surgery as the practice from colonic surgery is not easily transferable to adrenal surgery.