51st Annual Meeting of the American Pancreatic Association

Abstract Guidelines

(Please refer to page 2 for a sample abstract with the appropriate format)

1. Text format for each abstract is Times New Roman, 12-point font, flushed left. In addition:

   - **Title**: Bolded and in title casing (capitalize words that are four or more letters long) (Example: *Pre-diagnosis Cachexia Rather Than BMI is Associated With Worse Survival Outcomes in Patients With Pancreatic Cancer*).

   - **Author names**: Begin on a new line, first initials (no spaces in initials) and last name, use **superscripted** numbers to indicate multiple affiliations. The affiliation numbers go after the comma or after the period. (Example: J.I. Chang,¹ B.Z. Huang,² B.U. Wu.³)

   - **Affiliations**: Continue in italics **immediately after** the last author’s name and use superscripted numbers and semicolons to separate different departments/institutions. Affiliation must include division/department, institution, city, state (if within US) or country (if outside the US). (Example: ¹Internal Medicine, Kaiser Permanente Los Angeles, CA; ²Research and Evaluation, Kaiser Permanente Southern California, Pasadena, CA; ³Center for Pancreatic Care, Gastroenterology, Kaiser Permanente Los Angeles, CA.)

   **Example of affiliations from one institution with multiple departments:**
   A. Criscimanna,¹ M. Socorro,¹ M. Tandon,¹ A. Singhi,² F. Esni.¹,³ Departments of ¹Surgery and ²Pathology; ³University of Pittsburgh Cancer Institute, University of Pittsburgh, Pittsburgh, PA.

   - **Body text**: Begin on a new line, regular font, sub-headers (e.g. Background, Methods, Results, Conclusion)

   - Please see the attached abstract for full example.

2. Tables, figures, and references are not accepted.
3. No more than 300 words
4. Indicate in the **footer** if you wish to publish in Pancreas
Reconsidering Lymphadenectomy for Locoregional Resectable Non-Functioning Pancreatic Neuroendocrine Tumors

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**Background:** The current treatment guideline for locoregional resectable non-functioning pancreatic neuroendocrine tumors (PNETs) suggests that next to resection lymphadenectomy should be considered in tumors of 1 to 2 cm in size, and recommend lymphadenectomy for PNETs > 2 cm. However, the literature has shown ambiguous results. The purpose of this study was to assess the survival impact of lymphadenectomy in PNETs.

**Methods:** Patients that underwent pancreatectomy between 2004 and 2014 for non-metastatic PNETs 1 to 4 cm in size were identified from the National Cancer Data Base. Propensity score models predicting the odds of undergoing lymphadenectomy (≥1 nodes examined) were created, and patients were matched based on logit of the propensity score. Survival analysis was performed using the Kaplan-Meier method. Subset analysis was performed in patient with positive (cut-off, > 13 nodes examined) and negative (cut-off > 6 nodes examined) nodes.

**Results:** In total, 2795 patients were identified. 82.8% of patients underwent lymphadenectomy, 76.9% had negative nodes and the median number of nodes examined was 8 (IQR, 2-14 nodes). On multivariable analysis, lymphadenectomy was associated with tumor size > 2 cm (vs. ≤ 2 cm: OR, 2.55; \(P < 0.0001\)), academic facility (vs. non-academic: OR, 1.42; \(P = 0.0009\)), moderate/poor differentiation (vs. well: OR, 1.48; \(P = 0.0193\)), and negative margins (vs. positive: OR, 2.10; \(P < 0.0001\)). After matching, lymphadenectomy was not associated with survival benefit (3-year survival: 95% vs. 94%; \(P = 0.59\)). Similarly, extend of lymphadenectomy did not impact survival in patients with positive (3-year survival: 82% vs. 85%; \(P = 0.10\)) and negative (3-year survival: 95% vs. 95%; \(P = 0.10\)) nodes.

**Conclusion:** Although positive lymph nodes remain associated with less favorable survival outcomes, the results of this study suggest that lymphadenectomy is not associated with improved survival.