

50th Annual Meeting of the American Pancreatic Association

Abstract Guidelines

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: ¹*Internal Medicine, Kaiser Permanente Los Angeles, CA*; ²*Research and Evaluation, Kaiser Permanente Southern California, Pasadena, CA*; ³*Center 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*¹*Surgery and*²*Pathology*; ³*University 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*

SAMPLE

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, extent 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.