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.