Please send your comments to;

ipmn2022kyoto@gmail.com

Please visit HP of IAP 2022.

IAP & JPS 2022

JOINT CONGRESS OF
THE 26TH MEETING OF INTERNATIONAL ASSOCIATION OF PANCREATOLOGY (IAP) AND
THE 53RD ANNUAL MEETING OF JAPAN PANCREAS SOCIETY (JPS)

IAP & JPS 2022 in Kyoto

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Reunion

Towards a New Horizon

DATE : 7 [THU] - 9 [SAT] JULY, 2022

VENUE : KYOTO INTERNATIONAL CONFERENCE CENTER

THE 26TH IAP CONGRESS PRESIDENT : YOSHIFUMI TAKEYAMA, MD, PhD
PROFESSOR AND CHAIRMAN, DEPARTMENT OF SURGERY, KINDAI UNIVERSITY FACULTY OF MEDICINE

THE 53RD JPS CONGRESS PRESIDENT : KYOICHI TAKAORI, MD, PhD
PRESIDENT, NAGAHAMA CITY HOSPITAL

Group 1; Revision of HRS and WF

High Risk Stigmata (HRS) + Worrisome features (WF)

- Diagnostic modality

  CT and MRI/MRCP → CT and MRI/MRCP (+ EUS, if applicable) ?

HRS

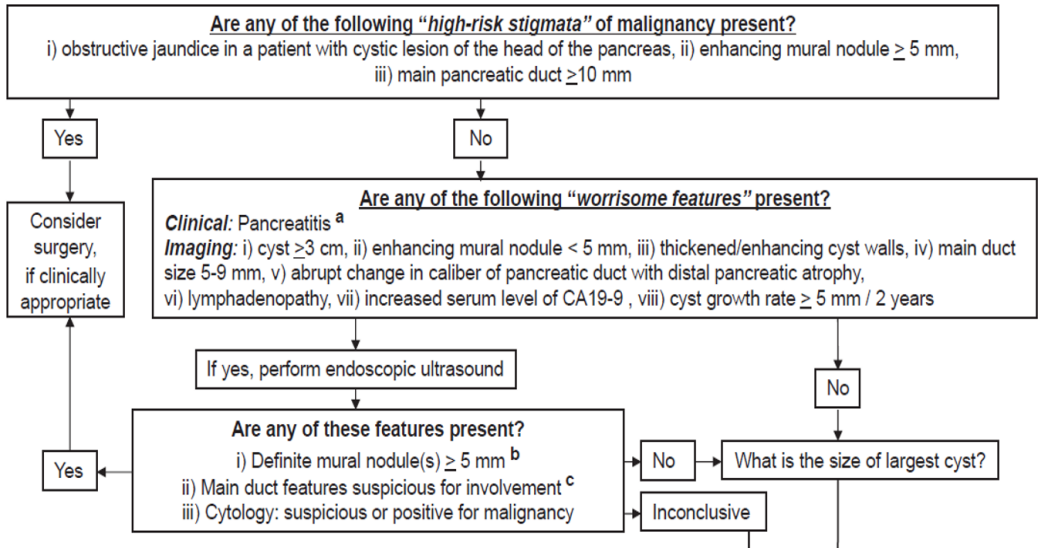
- Enhanced MN ≧ 5mm → ≧ 10mm ?
- MPD diameter ≧ 10mm → dilated MPD as WF ?
- Positive results of EUS-FNA cytology ?

WF

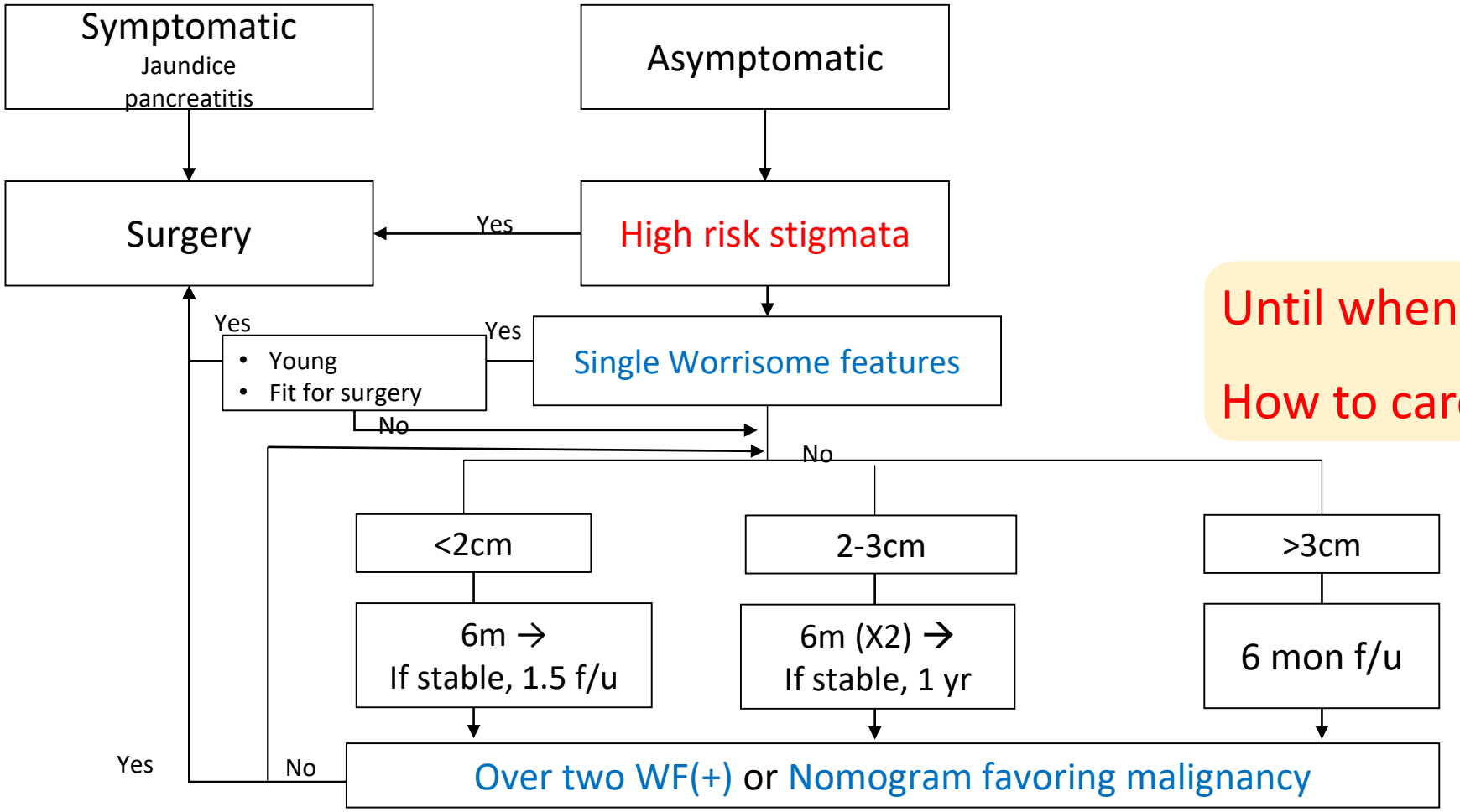
- Multiple WFs

  Surgery recommend, when ≧ 2 WFs ?

  Application of Nomogram ?



Group 2; Surveillance of non-resected IPMN



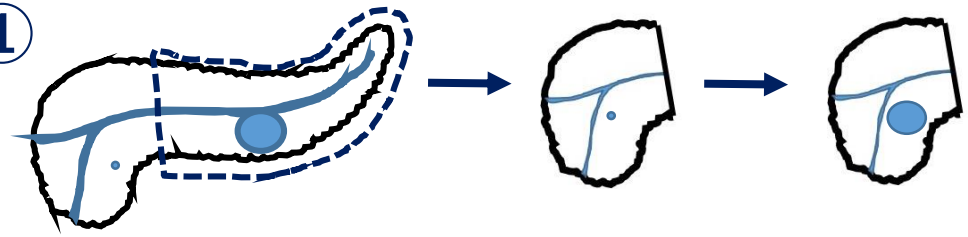
Until when?

How to care concomitant PDAC?

Group 3; Surveillance after resection of IPMN

Possible “clinically significant lesions” in the “remnant pancreas”
even after resection of “non-invasive IPMN”

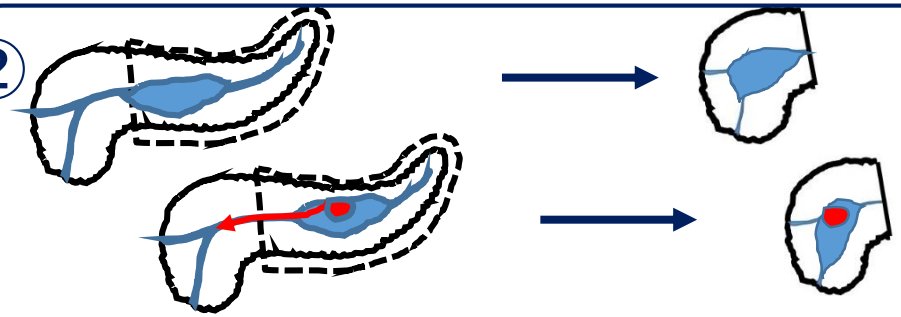
①



Progression of multifocal IPMNs

- New IPMN
- Residual IPMN

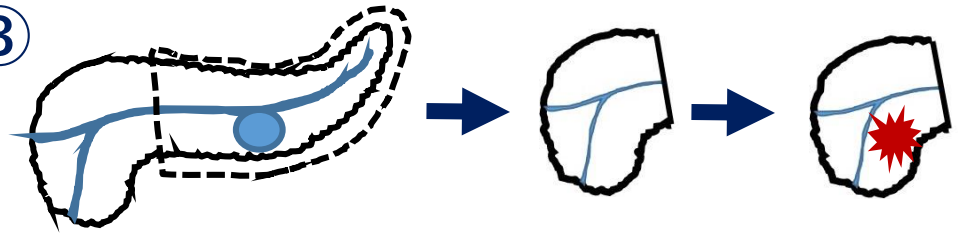
②



Recurrence of initial IPMN

- Margin positive
- Intraductal spread

③



Concomitant PDAC

Risk factors

- HGD (initial IPMN)
- Family history of panc. ca
- Margin positive

Image of significant lesions

- Solid mass
- MPD dilation
- Growth of cystic lesion

Group 4; Pathological aspects

- Usefulness of morphological types of IPMN for diagnosis, treatment, prediction of prognosis, and assessing risk of recurrence including concomitant carcinoma.
  → Associated with prognosis, and provide additional discrimination beyond grade of dysplasia.
- Handling of the intraductal oncocytic papiilary neoplasm (IOPN), formerly an oncocytic type IPMN.
  → IOPN should be separated from IPMN.
- Whether it is affordable or relevant to use "carcinoma in situ" as a synonymous to IPMN with HGD.
  → Carcinoma in situ = HGD. To use the term "Malignant" IPMN is not recommended.
- Usefulness of molecular analysis of IPMN tissues for diagnosis, treatment, and surveillance of IPMN.
  → *GNAS/KRAS* mutations are not associated with prognosis, and more data is needed for other markers.
- Application of knowledge for development of carcinoma associated/concomitant with IPMN on clinical practice.
  → IPMC and concomitant PDAC should be distinguished pathologically.
- Application and values of frozen section diagnosis.
  → LGD does not justify completion pancreatectomy, while additional resection for HGD/Invasive IPMN.
- Appropriate pathology reporting for IPMN including determination of T-factor.
  → Size of invasive component should be measured.
- Application and values of cytological analysis of cyst fluid and/or pancreatic juice.
  → Add value to risk assessment, important for clinical management .

Group 5; Markers in cystic fluid

CQ1- Can cyst fluid molecular markers differentiate IPMNs/MCNs from other types of cysts?

Recommendation:
Molecular markers can be used when the diagnosis of a pancreatic cyst is unclear and will alter surveillance.

CQ2- Can cyst fluid molecular markers distinguish IPMNs/MCNs with low-grade dysplasia from high-grade dysplasia or PDAC?

Recommendation:
TP53, SMAD4, CDKN2A and *PIK3CA* mutations are useful in identifying the presence of high-grade dysplasia and PDAC.