



KJS
Kosova Journal of Surgery

PACS
Pan-Albanian College of Surgeons



KOSOVA JOURNAL OF SURGERY

LIVER AND PANCREAS FOCUSED ISSUE

ALBERTO FERRERES, RIFAT LATIFI, JOSÉ M RAMIA: Redefining the Scalpel: Past, Present, and Future Perspectives on the Surgical Management of Pancreatic Ductal Adenocarcinoma (PDAC)

C. R. JÓDAR-SALCEDO; A. ROJAS-HOLGUÍN; D. LÓPEZ GUERRA; G. BLANCO-FERNÁNDEZ; JAÉN-TORREJIMENO: Arterial Resections in Pancreatic Cancer

JOSÉ MANUEL RAMIA, MARIO SERRADILA, CELIA VILODRE, BELÉN HERNÁNDEZ, GERARDO BLANCO, CÁNDIDO ALCÁZAR: From ERPANDIS to SPANDISPAN: Two Decades of Collaborative Research in Left Pancreatectomy

GUIDO PARQUET, ROSA SÁNCHEZ: Diagnostic and Therapeutic Approach to Acute Pancreatitis: Paraguayan National Consensus

LINDSAY BARTHOLOME, RIFAT LATIFI: Nutritional Support in Severe Acute Pancreatitis: A Narrative Review

DAI AILIN, REBEKAH YOUNG, VISHAL G. SHELAT: Severe Liver Trauma: Current Management

Volume 10, Issue 2
Liver and Pancreas Focused Issue
August 2026
ISSN: 3027-5008 (Online)
ISSN: 3027-5016 (Print)

This journal is a joint publication of the Kosova College of Surgeons & University of Prishtina

www.kosovajournalofsurgery.net

EDITORIAL

Hepatopancreatobiliary Surgery Today: From Reducing Mortality to Selecting the Right Patient

J.M. Ramia[1], Rifat Latifi[2]

[1] Editorial, Special Issue on Hepatopancreatobiliary Surgery

[2] Editor-in-Chief, Kosova Journal Surgery

This special issue brings together a collection of contributions on hepatopancreatobiliary (HPB) surgery, and the Editor-in-Chief's accompanying editorial rightly places those articles in context. This editorial aims to step back and reflect on why HPB surgery matters today, where the field has come from, and where it appears to be heading. HPB surgery is three surgeries under one name — liver, pancreas, and biliary tract — each with its own history, its own technical demands, and, increasingly, its own set of open questions.

For decades, risk defined HPB surgery. Major hepatectomy, pancreatoduodenectomy, and resections of the biliary tree were, and to some extent remain, operations with substantial morbidity and non-negligible mortality. Much of the last thirty years of progress in this field has been spent taming that risk: centralization of complex care, standardization of technique, better anesthesia and critical care, and the emergence of dedicated HPB training and fellowship programs. That effort has largely succeeded. Mortality after major liver and pancreatic resection in high-volume centers is now a fraction of what it was a generation ago, and quality metrics such as "textbook outcome" have become the new benchmark, precisely because survival alone is no longer a sufficiently ambitious goal[1]. The question the field faces now is not only "can we make this operation safer?" but "who truly benefits from having it at all?". That shift — from feasibility to selection — is, to me, the common thread running through liver, pancreatic, and biliary surgery alike, and it is the lens through which I would like to look briefly at each of the three.

Liver surgery

Diagnostic imaging has transformed how we approach liver disease. Multiphase CT and MRI, contrast-enhanced ultrasound, and increasingly the incorporation of artificial intelligence into image analysis are improving lesion characterization, detection of small or atypical tumors, and preoperative planning[2]. But better imaging is only part of the story. Perhaps the more important conceptual shift has been the move away from thinking primarily about what can be resected and toward thinking about what will be left behind: the future liver remnant now drives operative planning as much as the tumor itself, through volumetric assessment, functional testing, and strategies such as portal vein embolization or staged hepatectomy when the remnant is judged insufficient. In parallel, the field has become more disciplined about measuring what matters — standardized, comparable outcomes rather than isolated case series[1] — and about identifying which patients genuinely benefit from resection, as opposed to those for whom surgery adds risk without meaningful gain. Systemic therapy has been a genuine gamechanger for liver malignancy, with more effective and better-tolerated chemotherapy regimens converting some initially unresectable patients into surgical candidates, and surgical indications have gradually extended to less frequent but increasingly recognized scenarios. Within Europe

© 2026 The Author(s). Published by Kosova Journal of Surgery. This is an open access article distributed under the terms of the Creative Commons Attribution License (CC BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

specifically, the rising incidence of intrahepatic cholangiocarcinoma deserves particular attention, changing the case mix that liver units now manage and, in many centres, the balance of oncological versus benign indications for resection[3]. Finally, minimally invasive liver surgery — laparoscopic and, increasingly, robotic — has moved from a niche technique to an accepted, guideline-supported approach for an expanding range of resections, including major and technically demanding cases, with the learning curve and case selection now the main determinants of outcome rather than the approach itself[4].

Pancreatic surgery

Pancreatic cancer illustrates the same evolution in concentrated form. Diagnostic pathways have improved, though earlier and more accurate detection remains the single greatest unmet need in this disease. Technical refinements in pancreatoduodenectomy and left pancreatectomy, together with better, more standardized definitions of what constitutes a good outcome, have made quality comparison across centres more meaningful[1]. Systemic therapy has advanced substantially, and neoadjuvant strategies are now central to management of borderline resectable and some locally advanced tumors, which raises a genuinely difficult question this field is still learning to answer well: which patients actually benefit from proceeding to surgery after neoadjuvant treatment, and which do not, and by what criteria that decision should be made. Minimally invasive distal pancreatectomy has now been validated against open surgery in randomized comparison for resectable pancreatic cancer[5], and robotic pancreatoduodenectomy is following a similar, if more cautious, trajectory as experience accumulates. Enhanced recovery (ERAS) protocols and, increasingly, structured prehabilitation before surgery — optimizing nutrition, fitness, and physiological reserve in the weeks before the operating room — have become standard components of perioperative care, improving recovery and reducing complications[6]. Beyond cancer, two further areas exemplify the selection challenge directly. Intraductal papillary mucinous neoplasms are now managed through evidence-based guidelines that help distinguish lesions that genuinely warrant resection from those that can be safely observed, sparing many patients an unnecessary operation[7]. And in chronic pancreatitis, recent randomized evidence supports earlier surgery over a prolonged endoscopy-first approach in appropriately selected patients[8], while nutritional assessment and support — long underappreciated in this population — is increasingly recognized as integral to both the decision to operate and the outcome once surgery is performed.

Biliary surgery

Biliary surgery remains, in many respects, the most technically demanding branch of the three. Perihilar cholangiocarcinoma (Klatskin tumours) continues to challenge even experienced HPB surgeons because of its anatomical complexity and the need to combine major hepatectomy with biliary and often vascular reconstruction[9]. Minimally invasive approaches, laparoscopic and robotic, are being extended into biliary surgery for both benign and malignant disease, though this remains an area where caution and case selection are essential given the consequences of a biliary complication. What has changed most substantially, however, is the systemic and biological landscape: new chemotherapy and immunotherapy combinations have, for the first time in years, produced a meaningful survival benefit in advanced biliary tract cancer[10], and a deeper understanding of the molecular biology of cholangiocarcinoma is beginning to open the door to targeted treatment in selected patients. As in the liver and pancreas, better systemic options are reshaping the surgical conversation around resectability and timing, and are likely to make patient selection, treatment sequencing, and multidisciplinary discussion as important to outcomes in biliary cancer as the operation itself.

A common thread

Across all three organs, the story is the same. HPB surgery began as a discipline defined by its dangers, and the last generation of surgeons made these operations substantially safer. That achievement should not be understated, but it is no longer the frontier. The questions that now occupy liver, pancreatic, and biliary surgeons are less about whether an operation can be performed and more about whether it should be, in whom, and when — informed by better imaging, better systemic therapy, more rigorous outcome measurement, and a growing willingness to say no to surgery when the evidence suggests another patient will benefit more than this one. Getting that balance right, organ by organ and patient by patient, is, I believe, the real work of HPB surgery for the coming decade, and it is the evolution that this special issue, in its own way, reflects.

References:

1. Pretzsch E, Koliogiannis D, D'Haese JG, et al. Textbook outcome in hepato-pancreato-biliary surgery: systematic review. BJS Open. 2022;6(6):zrac149.

2. Chatzipanagiotou OP, et al. Artificial intelligence in hepatocellular carcinoma diagnosis: a comprehensive review of current literature. J Gastroenterol Hepatol. 2024. doi:10.1111/jgh.16663.

3. Vithayathil M, Khan SA. Current epidemiology of cholangiocarcinoma in Western countries. J Hepatol. 2022. PMID: 35977611.

4. Abu Hilal M, Hoogteijling TJ, Edwin B, et al. The Brescia internationally validated European guidelines on minimally invasive liver surgery. Br J Surg. 2025;112(6):znaf113.

5. Korrel M, Jones LR, van Hilst J, et al. Minimally invasive versus open distal pancreatectomy for resectable pancreatic cancer (DIPLOMA): an international randomised non-inferiority trial. Lancet Reg Health Eur. 2023. PMID: 37457332.

6. Melloul E, Lassen K, Roulin D, et al. Guidelines for Perioperative Care for Pancreatoduodenectomy: Enhanced Recovery After Surgery (ERAS) Recommendations 2019. World J Surg. 2020;44(7):2056-2084.

7. European Study Group on Cystic Tumours of the Pancreas. European evidence-based guidelines on pancreatic cystic neoplasms. Gut. 2018;67(5):789-804.

8. Issa Y, Kempeneers MA, Bruno MJ, et al; Dutch Pancreatitis Study Group. Effect of Early Surgery vs Endoscopy-First Approach on Pain in Patients With Chronic Pancreatitis: The ESCAPE Randomized Clinical Trial. JAMA. 2020;323(3):237-247.

9. Fernandes E, Yagi S, Kato K, et al. Changing concepts in perihilar cholangiocarcinoma resections and surgery. Int J Surg. 2026;112(6):12579-12587.

10. Oh DY, He AR, Qin S, et al. Durvalumab plus Gemcitabine and Cisplatin in Advanced Biliary Tract Cancer. NEJM Evid. 2022;1(8):EVIDoa2200015.

© 2026 The Author(s). Published by Kosova Journal of Surgery. This is an open access article distributed under the terms of the Creative Commons Attribution License (CC BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.