

# CURRENT PROTOCOL FOR MANAGEMENT OF PANCREATIC CANCER (OCTOBER 2005)

## **I. PRE-REFERRAL GUIDELINES**

Obstructive jaundice on initial presentation

1. Check LFTS, Clotting
2. Use Ultrasound as initial screening tool

CBD Stones confirmed: ERCP or laparoscopic bile duct stone management as per local expertise

CBD stone suspicious but not visualised, pancreatic head not visualised: MRI with MRCP

Pancreatic head mass or suspicion thereof: CT scan (abdomen and pelvis); chest Xray to exclude metastasis

## **II. MDT PROCESS AND PRE-OPERATIVE WORK-UP**

1. Staging of tumour by CT

Triple phase CT using pancreatic protocol

All CT Scans should be evaluated at an MDT with HPB input.

All patients undergoing surgery for suspected cancer should be triaged as  
Definitely irresectable  
Definitely resectable  
Doubtful resectability based on vascular invasion  
(Patients triaged to groups 2 and 3 should be audited for resectability rate)

CT scan report should specify:

Site of tumour: bile duct, head, neck, uncinata, body, tail

Size of tumour

Local invasion: vessels (SMA, SMV, PV, IVC), duodenum, stomach, liver hilum, colon

Metastasis: liver, peritoneum, distant lymph nodes (celiac etc.,)

CT scan should be within 4 weeks of a scheduled operation.

2. Role of additional investigations:

1. ERCP: Consider ERCP if patient not stented already
  - a. Avoid stenting provided patient is fit for surgery and surgery possible within 2 weeks and Bilirubin < 250 mg)

- b. AVOID metal stents if resectability not assessed at MDT
- 2. EUS: Role in patients with
  - a. Mass not seen on CT scan, but high suspicion of peri-ampullary carcinoma
  - b. Assess vascular invasion in borderline cases
  - c. Unresectable tumour and need for tissue diagnosis
  - d. Celiac plexus block
- 3. Laparoscopy: Only in selected cases (peritoneal disease, possible liver metastasis) discussed at MDT. No role for laparoscopic ultrasound for assessing vessel encasement.
- 4. PET: Role for diagnostic work-up doubtful, to be re-assessed in light of more literature
- 5. MRI/ MRCP: No role as routine for diagnostic work-up
- 6. CA-19.9: Baseline pre-operative value should be at minimal jaundice state where possible

### III. SURGERY

- 1. HDU bed for one day post-op
- 2. 4 units cross match
- 3. No role for extended lymphadenectomy (sampling of lymph nodes where appropriate)
- 4. Portal vein or Superior mesenteric venous resection to be done only for patients with definite CT/ EUS evidence of venous invasion (Audit outcomes in this group).
- 5. No role for **any** vascular arterial resections.
- 6. Pancreatic anastomosis: depending on gland texture (soft, friable, firm etc). Preferred: duct-to mucosa
- 7. Octreotide: 100 mcg subcutaneously 8 hrly, to start pre-op and continue to day 7
- 8. Drain fluid amylase on day 5.
- 9. Post-op oral feed within day 4, provided condition stable. No routine jejunostomy or NG /NJ feeds.
- 10. No TPN except in clinically significant pancreatic leaks

11. Aim discharge on day 14 (Audit discharge dates).
12. No routine pancreatic enzyme supplements.
13. If patient found to have inoperable disease, should have a biliary bypass and gastric bypass. Also consider coeliac plexus block (50% ethanol) (Audit outcomes in this group).

#### **IV. HISTOPATHOLOGY**

Current reporting exceeds minimum dataset as recommended by Royal College of Pathologists.

All cases discussed at MDT and appropriate adjuvant treatment decisions made.

#### **V. FOLLOW-UP SCHEDULE** for patients with **resected** cancers

1. 1<sup>st</sup> surgical outpatients: 4 weeks. Check wound, general recovery. Baseline post-operative CA-19.9 and routine bloods.
2. Referral for chemotherapy / chemoradiotherapy (ideally into national and international clinical trials) as appropriate. All referrals to be discussed at MDT and liaised with local oncology clinicians. See next page.
3. Assuming adjuvant treatment is commenced immediately and takes six months to complete, there should be no HPB Centre follow-up, to avoid duplication of assessments (clinical and investigational). SHARED CARE
  - a. All letters to be copied to appropriate clinicians
  - b. Watch for clinical symptoms of steatorrhea and treat as appropriate on clinical grounds
  - c. Investigations as per trial protocol
4. 2<sup>nd</sup> surgical outpatients: 8 months, CT scan on day of visit to HPB Centre. CA19.9
5. 3 monthly surgical follow-up thereafter. CA19.9 6 monthly
6. CT Scans in month 14 and 20. and then yearly for 5 years.

#### **VI. ADJUVANT THERAPY FOR PANCREAS CANCER**

1. No role for routine **neo-adjuvant** therapy. Neoadjuvant chemotherapy or chemoradiation may be considered in a small group of selected

patients with locally advanced disease, or only within the context of clinical trials

2. Resected patients who have received neo-adjuvant therapy should not be included in adjuvant therapy trials
3. Resected patients with R0 or R1 tumours should be ideally encouraged to enter the ESPAC 3 study. If not entering ESPAC 3, they should at the very least have a discussion with an Oncologist regarding the role of adjuvant chemotherapy, with the regimen to be used at the discretion of the Oncologist
4. Resected patients with R2 tumours should be considered for adjuvant chemoradiation

## **VII. ADVANCED PANCREATIC CANCER**

1. Patients should be considered for entry into the FRAGEM study (Fragmin and Gemcitabine) or the PARC study (Gemcitabine, Cetuximab and radiation)
2. Palliation of gastric outlet obstruction: Consider
  - Duodenal stents
  - Surgical bypass