Early diagnosis of pancreatic cancer

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The importance of early diagnosis in Pancreatic cancer

- Poor prognosis – 5yr survival 7.3%[1] for all diagnosed.

- Surgery only chance of cure - still then 5yr survival only 15-20%

- Only 10% of those diagnosed will undergo surgery
    - 40% present with metastases
    - Aggressive cancer
    - More common with age
    - Patients decondition rapidly

Stats from Cancer Research UK website

How can we increase surgery rates?

Early diagnosis	Prevent deconditioning
Index of suspicion - investigate unexplained symptoms Screening	PERT and dietetics Prehabilitation Rapid access to surgery

Index of suspicion

- Who is at risk?
  - Intrinsic risks
    - increasing age
    - Male sex
    - Family history
    - Genetic predisposition
  - Disease risk factors
    - Chronic/hereditary pancreatitis (rare)
    - Diabetes mellitus
    - Obesity
  - Extrinsic risks
    - Smoking
    - High alcohol use

Index of suspicion

- Specific symptoms depend on the location and stage of tumour
  - Tail/body – worry about new onset diabetes in adults with normal BMI
  - Head/neck – pruritis, jaundice

- General symptoms
    - Fatty food intolerance with bloating, colic, early satiety and steatorrhoea
    - Lethargy, weight loss
    - Back/shoulder pain
    - Dyspepsia, nausea, vomiting
    - Change in bowel habit

- Asymptomatic patient with incidental findings
    - Deranged LFTs in the absence of gallstones
    - Dilated common bile duct and/or pancreatic duct
    - Pancreatic cyst
    - Raised Ca 19-9

Screening for pancreatic cancer

- 10% of pancreatic cancers have a genetic basis
- Families with two or more first-degree relatives (parent, sibling, offspring) with pancreatic cancer.
- Families with three or more relatives with pancreatic cancer.
- Families with an associated cancer syndrome and at least one case of pancreatic cancer.
  - BRCA2 mutation
  - Familial Atypical Multiple Mole Melanoma (FAMMM) syndrome (CDKN2A)
  - Hereditary Non-Polyposis Colorectal Cancer (HNPCC)
  - Peutz-Jeghers syndrome.
  - Hereditary pancreatitis (SPINK/PRSS1)

Screening for pancreatic cancer

- Currently there is no *proven* screening program for PDAC
- We refer patients to the EUROPAC registry
    - Based in Liverpool
    - Usually from age 40
- Consists of:

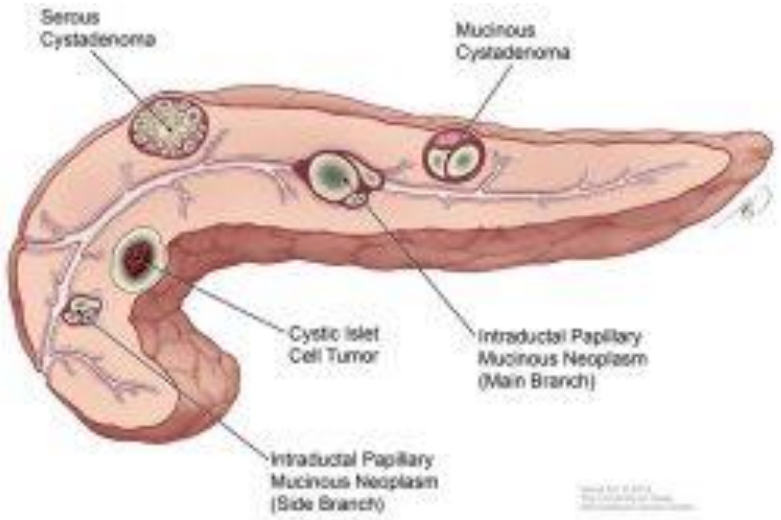
    Baseline CT, LFTs, Ca19-9 and HbA1c

    Yearly endoscopic ultrasound and bloods

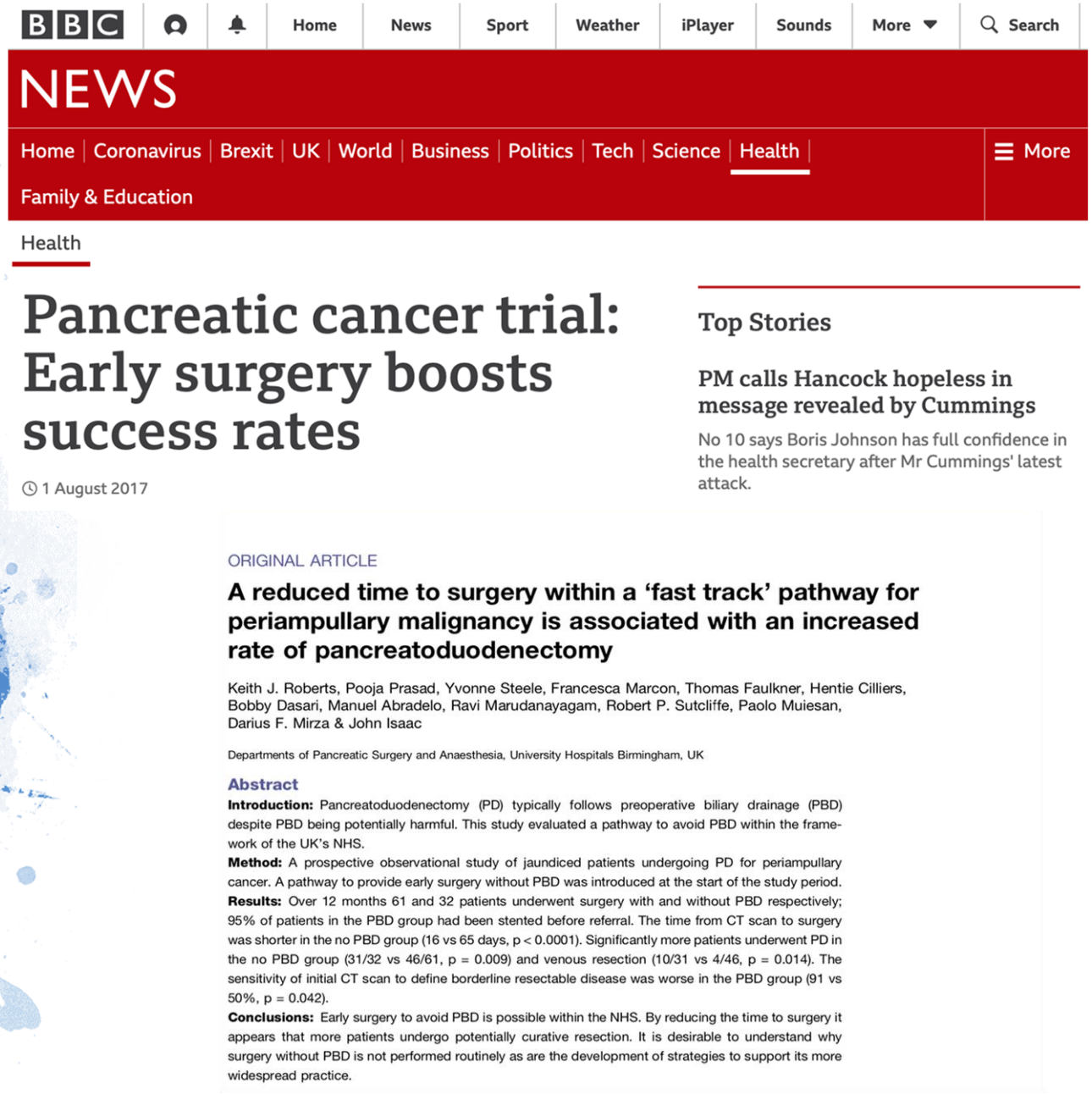
    MRI pancreas every 3 years
- Patients can either just join the registry, or enter the screening program

Cysts of the pancreas

- Wide spectrum of malignant potential
- Most are innocent, but hard to differentiate so are followed up with either CT, MRI or EUS
- Aim to operate before malignant transformation



Rapid access to surgery



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Pancreatic cancer trial: Early surgery boosts success rates

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ORIGINAL ARTICLE

A reduced time to surgery within a 'fast track' pathway for periampullary malignancy is associated with an increased rate of pancreatoduodenectomy

Keith J. Roberts, Pooja Prasad, Yvonne Steele, Francesca Marcon, Thomas Faulkner, Hentie Cilliers, Bobby Dasari, Manuel Abradelo, Ravi Marudanayagam, Robert P. Sutcliffe, Paolo Muiesan, Darius F. Mirza & John Isaac

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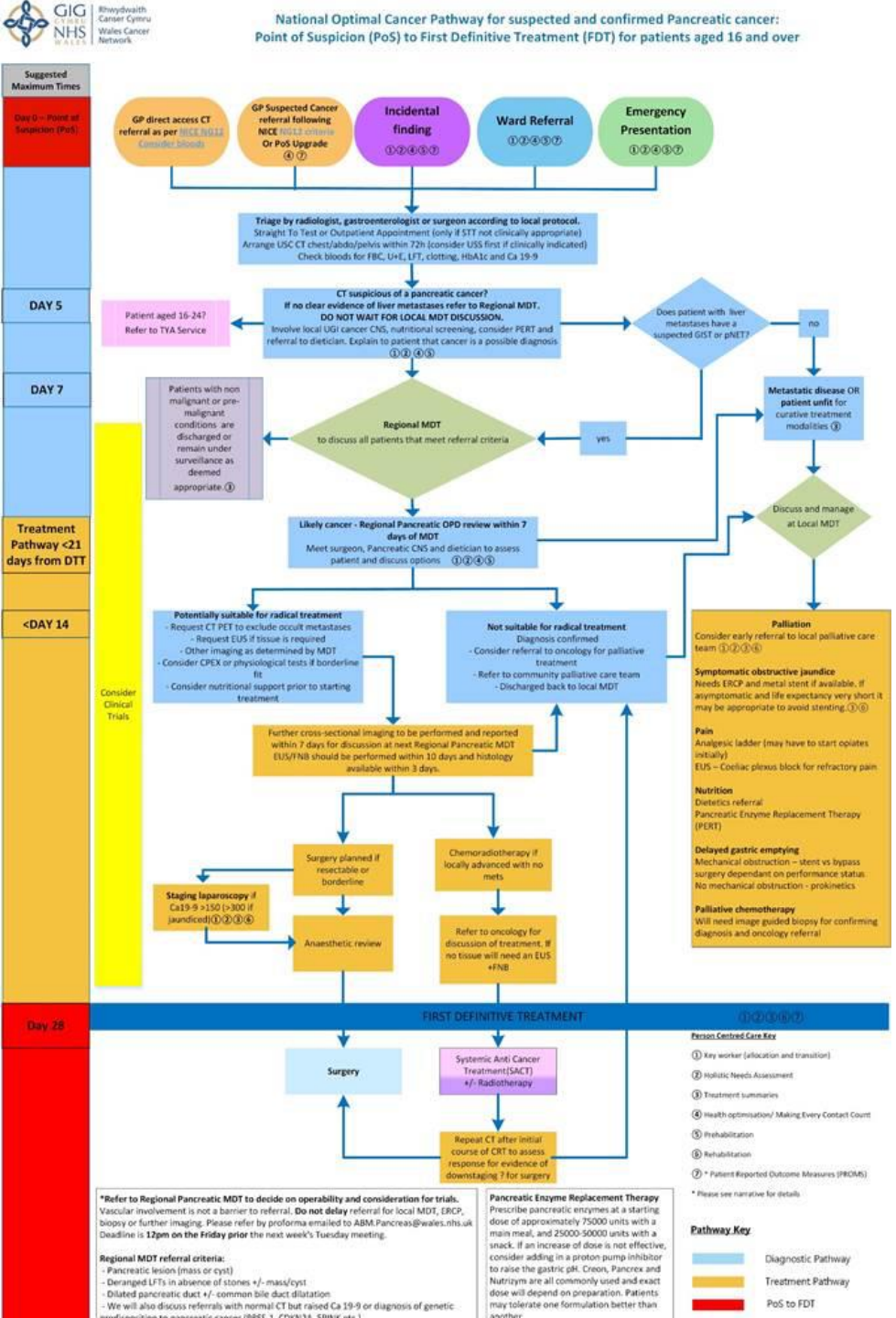
Abstract

Introduction: Pancreatoduodenectomy (PD) typically follows preoperative biliary drainage (PBD) despite PBD being potentially harmful. This study evaluated a pathway to avoid PBD within the framework of the UK's NHS.

Method: A prospective observational study of jaundiced patients undergoing PD for periampullary cancer. A pathway to provide early surgery without PBD was introduced at the start of the study period.

Results: Over 12 months 61 and 32 patients underwent surgery with and without PBD respectively; 95% of patients in the PBD group had been stented before referral. The time from CT scan to surgery was shorter in the no PBD group (16 vs 65 days, $p < 0.0001$). Significantly more patients underwent PD in the no PBD group (31/32 vs 46/61, $p = 0.009$) and venous resection (10/31 vs 4/46, $p = 0.014$). The sensitivity of initial CT scan to define borderline resectable disease was worse in the PBD group (91 vs 50%, $p = 0.042$).

Conclusions: Early surgery to avoid PBD is possible within the NHS. By reducing the time to surgery it appears that more patients undergo potentially curative resection. It is desirable to understand why surgery without PBD is not performed routinely as are the development of strategies to support its more widespread practice.



National Optimum Pathway for PDAC

- Aims
  - Speed up diagnosis and treatment
  - Avoid biliary stent use in resectable patients
  - Encourage use of PERT from diagnosis
  - Standardise care

Diagnosing pancreatic cancer

History suggestive of pancreatic cancer?

Get a CT abdomen/pelvis on a USC basis and check bloods

- USS will miss 10% of pancreatic cancers
- Colonoscopy/gastroscopy unhelpful

Consider referral to Rapid Diagnostic Clinic if available in your area

1.2.5 Consider an urgent direct access CT scan (to be performed within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss **and** any of the following:

- diarrhoea
- back pain
- abdominal pain
- nausea
- vomiting
- constipation
- new-onset diabetes. **[2015]**

NICE [NG12]

Now what?

- Look out for the report
- Radiological findings
  - Pancreatic lesion (mass or cyst)
  - Dilated pancreatic duct (+/- dilated CBD)
  - Normal CT but raised Ca 19-9 or genetic predisposition to PDAC
- Please refer any of these findings directly to us in Swansea
- We don’t have capacity to discuss cases with obvious metastatic disease from out of area, so may return these to be referred to your local hospital MDT. If you aren’t sure, please refer to us and we will advise.

How you can help us make the best decision for your patient…

- If it might be cancer refer early – don't wait for local MDT or clinic appointment
- Contact: SBU.pancreas@wales.nhs.uk
    - Performance status
    - Previous pancreatitis/alcohol use
    - Timing of onset for pancreatitis
    - Make sure the scans and reports go across
    - Old scans always helpful

What do I tell my patient?

- Be honest – explain that there is an abnormality with the pancreas and you are worried that it could be something serious such as a cancer
- Let them know we aim to give an answer within a week

What can I do whilst we wait?

- Optimise!
  - Document weight loss
  - Start them on PERT and refer to a dietician
  - Check their fasting blood glucose and treat accordingly – patients with loss of parenchyma due to tumour or atrophy may develop Type 3c diabetes, which requires insulin.
  - Correct any iron deficiency (PEI can cause this)
  - Exercise advice
- If symptomatically jaundiced make a parallel referral to local hospital for consideration of ERCP

Referring to the Pancreatic MDT

- Referral proforma can be found at https://collaborative.nhs.wales/networks/wales-cancer-network/clinical-hub/cancer-site-groups/upper-gastrointestinal-cancers/pancreatic-cancer/
- Fill out either electronically or by hand and scan in then email to: SBU.pancreas@wales.nhs.uk
- MDT cut off is 12pm on a Friday for the following Tuesday
- We aim to email back the outcome by close of day Wednesday.
- If you aren't sure talk to our Pancreatic Cancer Nurse specialists Kathy and Kellie

Summary

Wide variety of presentations

Speed is important

There is a lot that you can do as a GP early on

- PERT
- Dietetics referral
- Managing diabetes
- Helping with communication

Final thought...

Nearly 50% of diagnoses are made via an emergency presentation and 88% of those diagnosed via this route will die within one year. Survival is 3 times higher for patients diagnosed via GP referral.