Pancreatic Cancer UK

Dietetic management and pancreatic cancer

Wednesday 6th December 2023, 09.00 – 13.00

Q&A

During the event, some of the questions were responded to via message. You can see these below. The other questions were responded to live which you can see in the video recording.

Question	Answer
Which cut off do you use for the HGS?	We use <16kg for women, <27kg for men We don't use cuts offs, is there a reference for those cut offs? We use the centiles within the dynamometers we use or use the information within the PENG book.
Do you do any functional assessments in addition to the handgrip such as sit to stand or 6 min walk test?	Not currently but these are realy useful to do and a lot of them can be done easily in outpatient settings e.g. sit to stand.
If patient is diagnosed with neuroendocrine tumor of pancreas , how to evaluate sarcopeia	Exactly the same, grip strength / calf circumference would still be applicable.
Is grip strenght measurement a good indicator only to assess patient's sarcopenia problem? Thanks for your sharing, very informative and easy to understand.	No lots of things you can do including sit to stand test / SARC F questionnaire / calf circumference - just depends on what you have available or what you can implement.
is there a standardised tool that combine MUST and sarcopenia?	R-MAPP tool - an app combines MUST and SARC-F or just measure HGS / Calf circumference in addition.
thanks for the precise and educative presentation. please, what exercise would you consider apart from walking to improve muscle mass in 60years and above patient with sarcopenia? Thank you	If there are groups such as Macmillan Move more or exercise on prescription then exercise specialists can work with the individual to determine what their fitness level is like and what they could do to improve their muscle mass. Weight training can be useful and group exercise programmes often motivate people and provide peer support for those who wouldnt normally undertake exercise.
what investigations would you ask for if looking at other causes of symptoms and already taking high dose PERT?	SeCHAT if considering bile acid malabsorption, also important to look at past medical history and any other causes e.g cholecystecomy, or have they always had issues with bowels
If you're getting to doses of 250,000 units+ with ongoing steatorrhoea would you switch brands first? What other causes are we looking for?	Switching brands could be useful. Can check sechat if considering bile acid malabsorption and consider past medical history and any other causes of bowel symptoms or weight loss. Also check they are on a PPI or if they need to take their PERT differently e.g delayed gastric emptying

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for gastrectomy patients, whould you recommend to swallow creon with yoghurt? I mean if they're eating something salty and they have to take something acidic to swallow the pills.. I wonder if this can be bothersome	Yes, yogurt or jam etc, but you're right it is bothersome and can cause another barrier to poor PERT compliance, particularly if they are out of the home or having snacks
Can we still give Pancrex V into a gastric feeding tube when they are denatured with a pH of 4 and these are not enteric coated? Is a jejunal feeding tube preferable?	Pancrex can be given via NGs or PEGs but should also be prescribed a PPI to help reduce the risk of denaturing. If they are not NBM they can also take PERT such as creon or nutrizyme orally while the feed is running
Patients on PN would need any special arrangement of PERT? Thanks for the sharing.	If patient receiving PN, no PERT is required. It is only when EN or oral diet introduced that PERT is required
How common is SIBO in pancreatic Cancer patients? How do you diagnose?	Probably more common than we think! The 2019 paper was 63% pancreatic cancer patients vs 13% healthy individuals
would you suggest loperamide for loose stools if ongoing	As discussed, can be used, but ensure all other causes are excluded as well if concerns
is there any evidence that diarrhea affects the bioavailability of bile acids	I know that if too much bile acid is lost from the body due to diarrhoea, there is an increased risk of the formation of gallstones and kidney stones, but I'm not sure re: specific evidence re: bioavailability, sorry.
For nutritional management of SIBO would you recommend lactose and gluten restriction like we do in IBS?	There is some evidence to suggest a low FODMAP diet is beneficial in SIBO patients, but I wouldn't recommend it in patient with pancreatic cancer as it will likely exacerbate malnutrition
can these patients be started on SGLT2 therapy?	generally speaking we dont. if a patient is experiencing rapid weightloss SGLT2 can exacerbate this, equally if they have experienced hyperglycaemia it can exacerbate issues with uti/thrush and added weightloss

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