

Optimal care pathway for people with pancreatic cancer

Quick reference guide



Please note that not all patients will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Prevention: The two most effective prevention strategies include avoiding tobacco smoking and maintaining a normal body weight.

Risk factors: Tobacco smoking is the most established risk factor (increasing significantly with greater intensity and duration). Other risk factors include cystic lesions of the pancreas, obesity, a family history, older age, chronic pancreatitis, longstanding type 2 diabetes mellitus, male gender, Asian/Pacific Islander ethnicity, chronic alcohol

consumption, heavy occupational exposure to certain pesticides, dyes and chemicals used in metal refining.

Having certain hereditary conditions also increases a person's risk of pancreatic cancer.

Early detection: People with a strong family history of pancreatic cancer and related hereditary conditions

should be referred to a genetic counsellor, geneticist or oncologist for possible genetic testing.

Potential imaging for the surveillance of pancreatic cancer in high-risk populations includes endoscopic ultrasound for small pancreatic head tumours and blood tests (CA 19-9 and carcinoembryonic antigen (CEA) and liver biochemistry).

Step 2

Presentation, initial investigations and referral

Signs and symptoms: Many cases present with non-specific symptoms or are asymptomatic until advanced stages of the disease process.

Symptoms for cancer of the head and neck of the pancreas include jaundice that is progressive, together with unexplained weight loss and abdominal pain that may radiate to the back. Symptoms for cancer of the pancreas include pain that is often severe, unrelenting, of a short duration, and associated unexplained weight loss.

General/primary practitioner investigations: Consider an abdominal CT scan; early referral is indicated, usually prior to a definitive diagnosis being made.

Where jaundice is present, the following should be ordered within 48 hours and followed up as rapidly as possible:

- liver function tests
- abdominal ultrasound
- CT where appropriate.

Referral: Refer all patients with suspected or proven pancreatic cancer to a specialist linked with a multidisciplinary team within one week. The multidisciplinary team should have a rapid access program.

Communication – lead clinician to:¹

- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

Step 3

Diagnosis, staging and treatment planning

Diagnosis and staging: Diagnosis of a mass is primarily by imaging. Contrast-enhanced multidetector computed tomography scan (MDCT) according to suggested pancreatic protocol is suggested.

If diagnostic uncertainty still remains, conduct:

- endoscopic ultrasound with or without biopsy
- contrast-enhanced MRI of the pancreas or magnetic resonance cholangiopancreatography (MRCP) in patients who cannot tolerate contrast or where diagnostic uncertainty remains
- diagnostic laparoscopy with or without laparoscopic ultrasound.

Diagnostic and staging investigations should be completed within one week.

Treatment planning: Immediate treatment is often required before a full multidisciplinary meeting ratifies details of the management plan (which should include full details of the response assessment).

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Treatment for resectable pancreatic cancer:

Only eight to 12 per cent of patients have disease amenable to surgical resection at the time of presentation as the majority present with metastatic or locally advanced disease (Speer et al. 2012).

Surgery with or without chemotherapy (adjuvant or neoadjuvant chemotherapy, or adjuvant chemoradiation may be appropriate).

Treatment for unresectable pancreatic cancer:

If unresectable, any other treatment is palliative as pancreatic cancer is unlikely to be cured by chemotherapy and radiation therapy. The most commonly used therapies include:

- endoscopic or radiological intervention
- palliative surgical interventions
- chemotherapy with or without chemoradiation

- coeliac plexus or intrapleural block.

Palliative care: Specialist palliative care is recommended for the majority of patients with pancreatic cancer. Early referral can improve quality of life. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- discuss treatment options with the patient/carer including the intent of treatment as well as the risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

For detailed information see www.nhmrc.gov.au/guidelines/publications/subject/Cancer.

Step 5

Care after initial treatment and recovery

Most patients with pancreatic cancer are palliated. If a patient is thought to have been cured after their treatment, then care in the post-treatment phase is driven by predicted risks.

Cancer survivors should be provided with the following to guide care after initial treatment.

Treatment summary (provide a copy to the patient/carer and general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care plan (provide a copy to the patient/carer and general practitioner) outlining:

- medical follow-up required (tests, ongoing surveillance)
- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the patient's general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: It is likely that their current symptoms will worsen progressively. This should be managed following discussion at a multidisciplinary clinic in consultation with palliative care specialists.

Treatment: Where possible, refer the patient to the original multidisciplinary team. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Palliative care: Specialist palliative care is recommended for the majority of patients with pancreatic cancer. Referral should be based on need, not prognosis. Early referral can improve quality of life.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

Step 7

End-of-life care

Palliative care: Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the patient/carer
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.