Frank Burton Memorial Update on Pancreato-biliary Cancers

Diagnosis and management of pancreatic cancer: common dilemmas

Moderators: **Banke Agarwal, MD**
Paul Buse, MD

- Robert Hawes, MD

Evaluation of patients with obstructive jaundice and dilated CBD without stones in CBD or gallbladder

Carlos Fernandez-del-castillo, MD

What to do and not do before seeking surgical consultation for patient with suspected pancreatic cancer

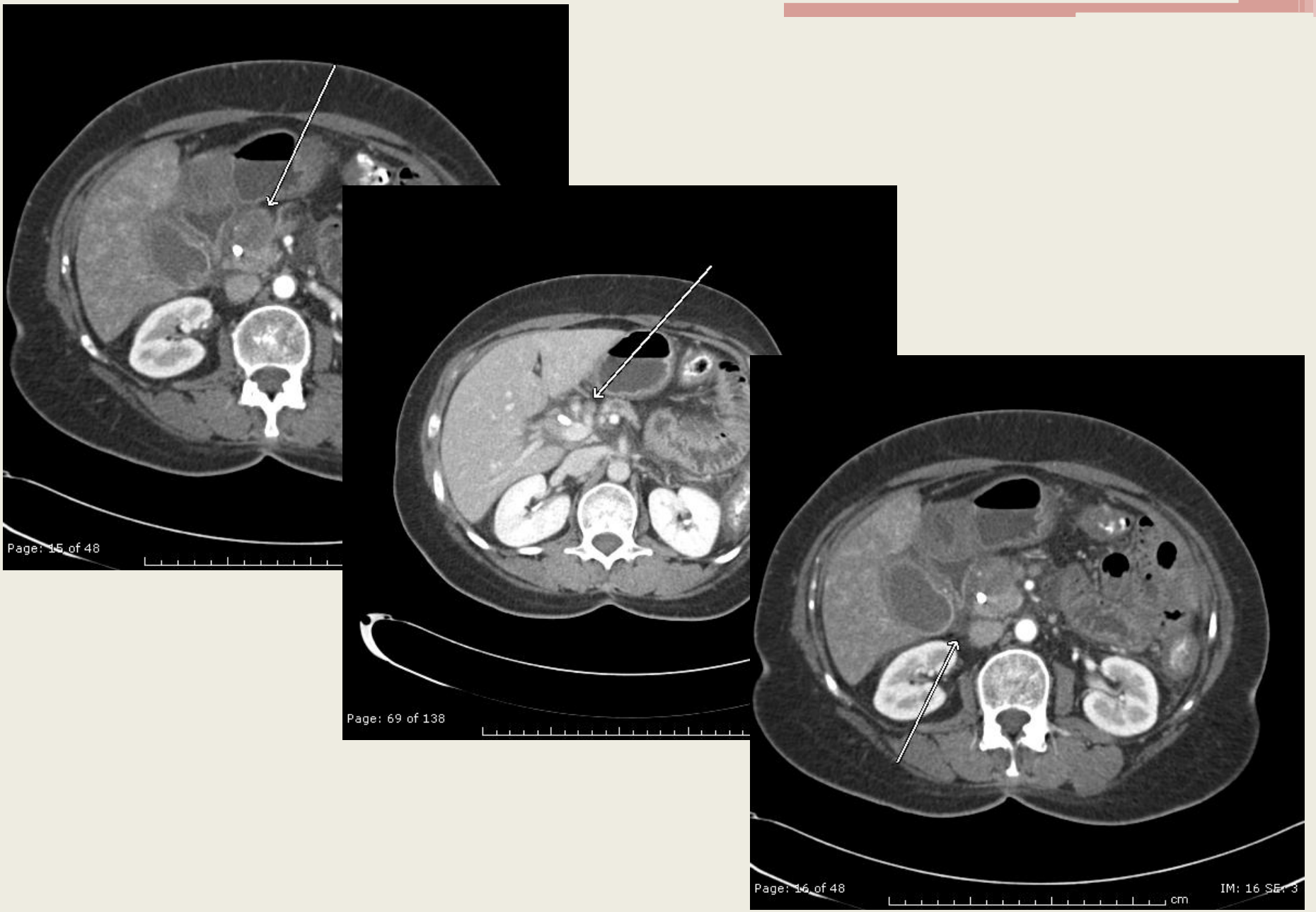
Robert Wolff, MD

Is R1 or R2 resection of pancreatic adenocarcinoma of any benefit or does it just increase morbidity

Case 1

- A 70 year old woman develops painless obstructive jaundice.

- CT abdomen with contrast (non-pancreatic protocol)
  - reveals dilated CBD and
  - a mass lesion in the pancreatic head about 4 cm in size
    - with enlarged peripancreatic lymph nodes and
    - Adjacent small ascitic fluid collection
    - No obvious vascular infiltration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cm
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What is the appropriate next step in the management of this patient

1. Whipple resection ASAP
2. EUS with FNA
3. CT with pancreatic protocol
4. ERCP and placement of metal biliary stent
5. None of the above

Dr Fernando-del-Castillo

- What proportion of pancreatic cancers are actually resectable at time of diagnosis
- How does the size of tumor correlate with resectability
  - What are the chances that a 4 cm tumor is actually resectable despite no obvious vascular involvement on CT/MRI scans
- Amongst pancreatic cancers that are found resectable on imaging, how many of them are actually found resectable at surgery

Rob Hawes

- Is there a role for EUS in this patient. If yes, what?

- The pancreatic surgeon cannot operate on this patient for 2 weeks due to busy schedule.
  - Is there a role for ERCP in this patient
  - What kind of biliary stent is appropriate for placement in this patient- metal or plastic

Dr Wolff

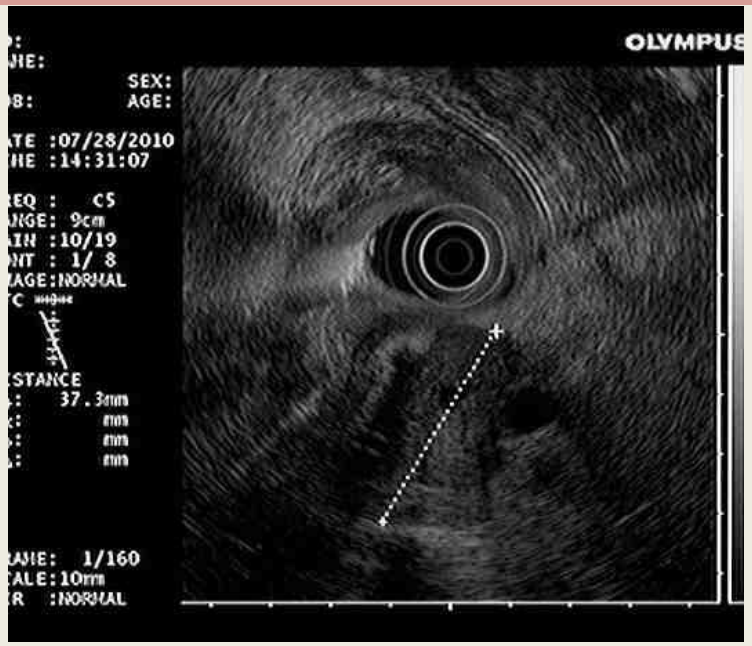
- Should this patient be taken for surgical exploration ASAP or be further investigated for diagnosis and staging

Dr Fernando-del-Castillo

- Should CT with pancreatic protocol always be performed even if there is no evidence of unresectability on CT with contrast (non- pancreatic protocol)

Dr Hawes

- During ERCP, CBD cannulation is very difficult. Appropriate next step is
  - Try pre-cut sphincterotomy
  - Send for PTC
  - Refer to a more experienced ERCPist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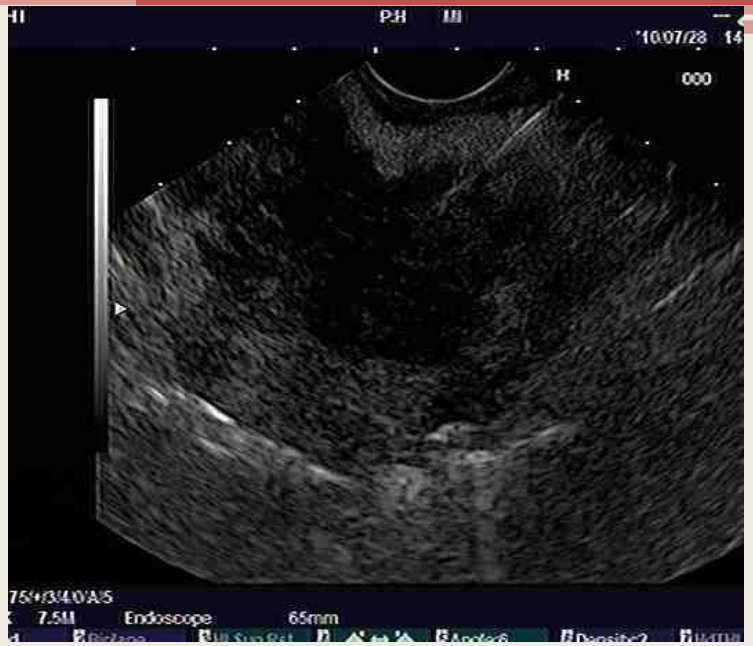
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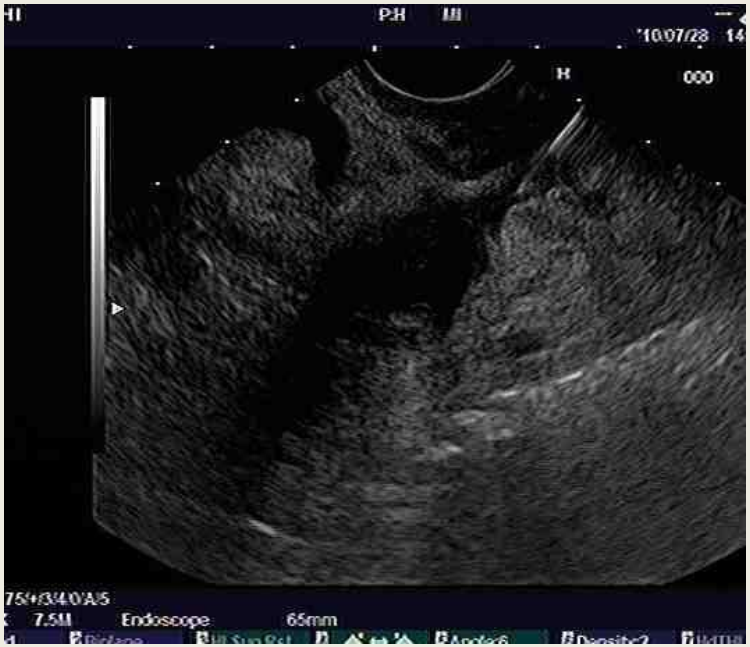
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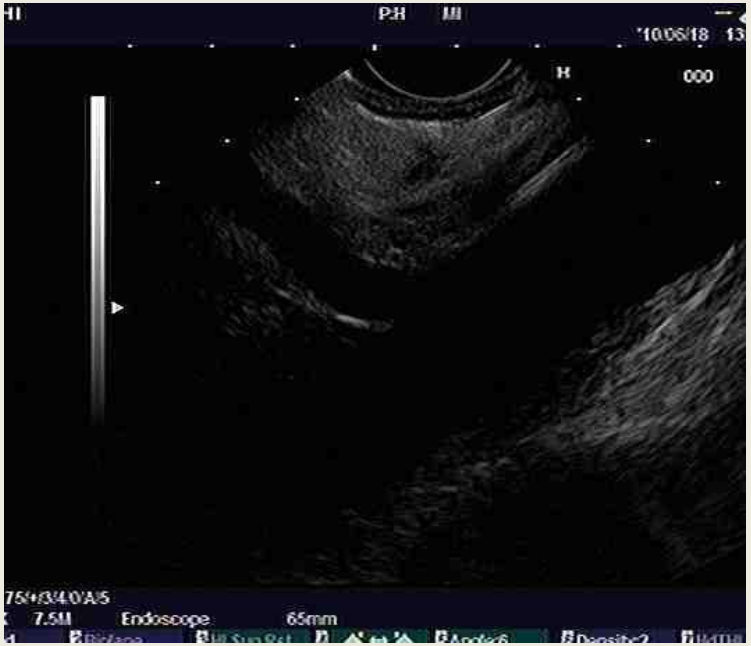
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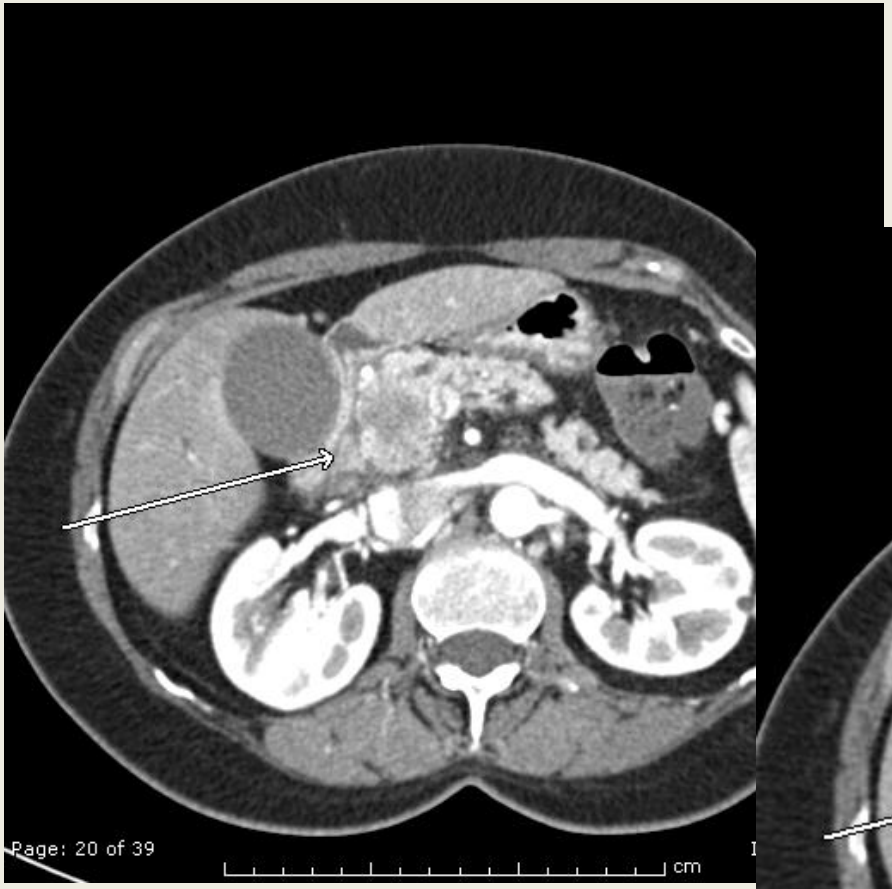
Dr Wolff

- How will the presence of malignant cells in the peri-pancreatic/peri-tumoral fluid collection influence further management of this patient

- EUS revealed 2 enlarged celiac lymph nodes with metastatic cancer. Is surgery an option in this patient

Case 2

- A 38 year old woman with two daughters 3 and 6 years old, develops back pain and weight loss of 15 lbs. in 1 month.
- CT abdomen:
  - dilation of the pancreatic duct
  - enlargement of head of pancreas without an identifiable mass lesion.
- EUS:
  - 40 mm mass lesion in the pancreatic head. FNA: poorly differentiated mucinous adenocarcinoma.
  - There are 2 celiac nodes. FNA- metastatic adenocarcinoma
- CT pancreatic protocol:
  - Pancreatic mass about 4 cm in size with >50% encirclement of the SMA and involving the portal confluence.
- The patient is sobbing uncontrollably after hearing the diagnosis.
  - The husband is very anxious and wants to do everything for treatment
- Patient has no other co-morbidities.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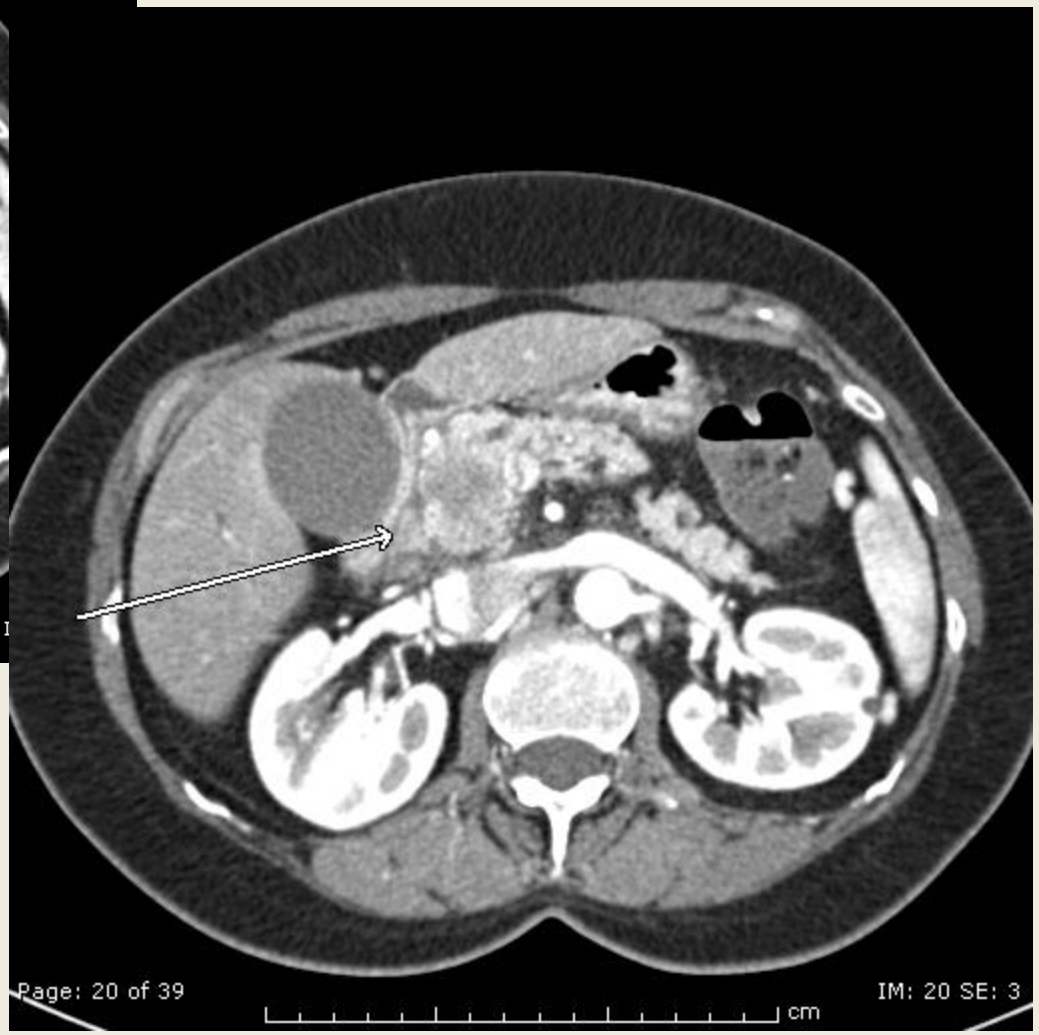
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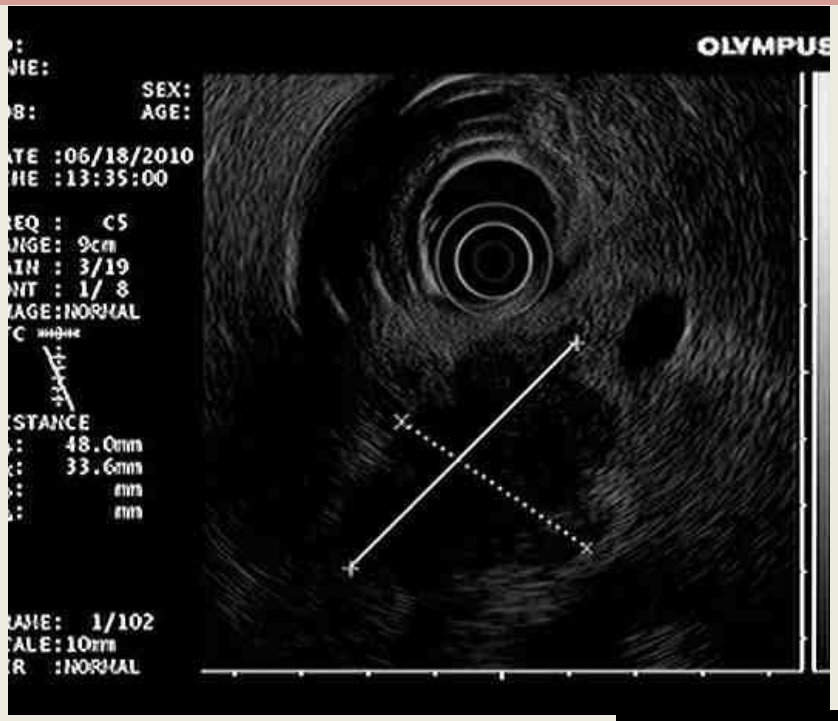
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33.6mm
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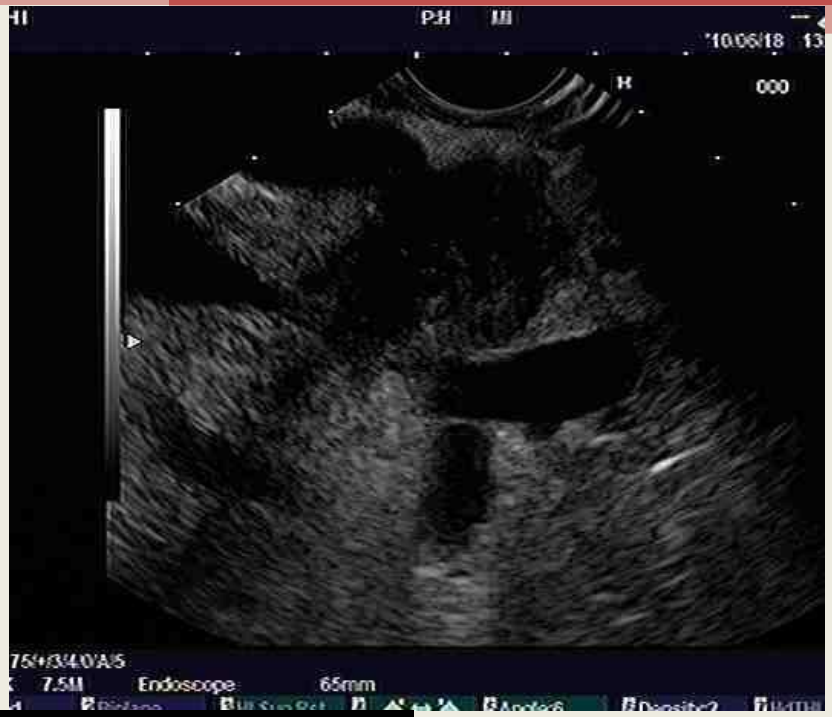
AME: 1/102
ALE:10mm
R :NORMAL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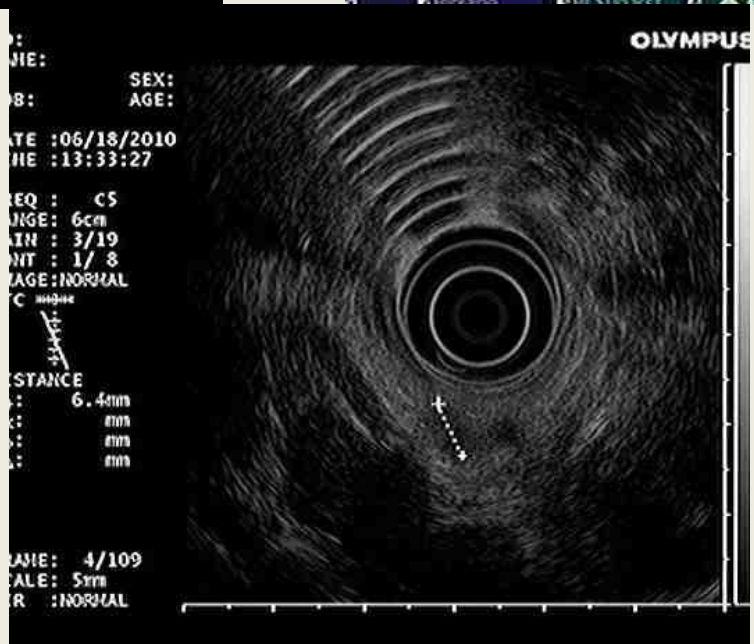
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STANCE
6.4mm
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AME: 4/109
ALE: 5mm
R :NORMAL

Appropriate management of this patient would be

1. Whipple resection with reconstruction of the portal vein followed by aggressive chemo-radiation

2. Pre-operative chemo-radiation followed by surgery only if there is no evidence of tumor progression while on treatment

3. Staging laparascopy to further evaluate the tumor extent prior to making definitive treatment decisions

4. Palliative treatment

Rob Hawes

- What is the sensitivity of CT abdomen with contrast performed in community hospital setting for identifying pancreatic tumors

- What is the appropriate next test in patients with suspected pancreatic cancer that is not identifiable on CT with contrast
  - EUS vs CT with pancreatic protocol
  - Is there any data to support the use of one over the other

Fernando Del-Castillo

- Is “Aggressive surgical approach” justifiable in this patient given her young age and good functional status
  - What added benefit could be accrued by such an approach and what are its potential disadvantages
- Does tumor biology play a role in choosing patients for “aggressive surgical approach”

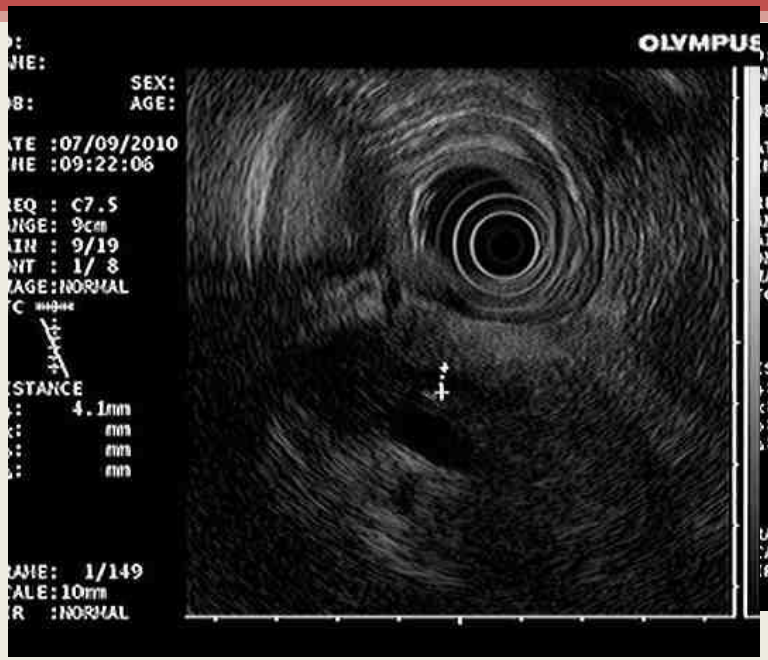
Bob Wolff

- Would “a more aggressive chemoradiation” protocol be justifiable in this patient
  - Is “FOLFIRINOX” the new standard of care for a patient like this

- What are the potential benefits *vs* risks associated with a more aggressive approach

Case 3

- A 60 year woman has two episodes of acute pancreatitis in last 4 months.
- CT scan:
  - dilated PD in the body and tail
  - but no identifiable pancreatic mass.
- EUS: PD normal in pancreatic head but dilated in body and tail.
  - 22 mm focal mass lesion at the site of sudden dilation of PD
  - FNA
    - atypical cells but within normal range (some inflammatory cells also present)
  - ERCP :
    - PD stricture.
    - Brushings: atypical cells but within normal range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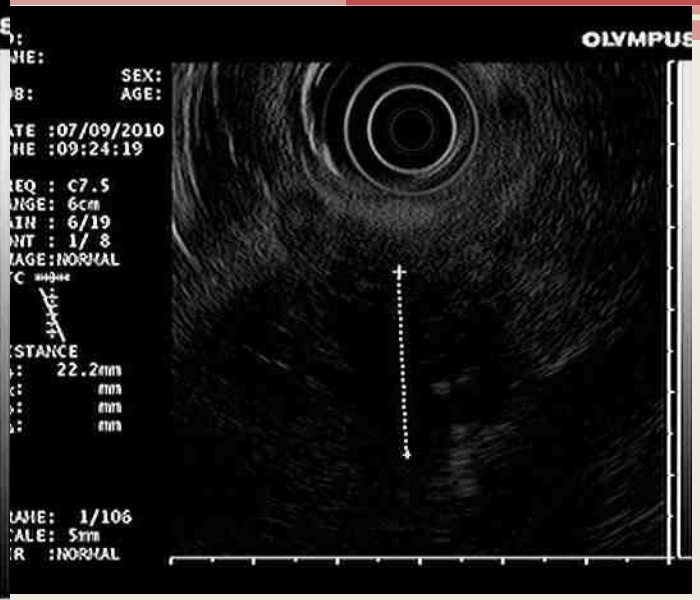
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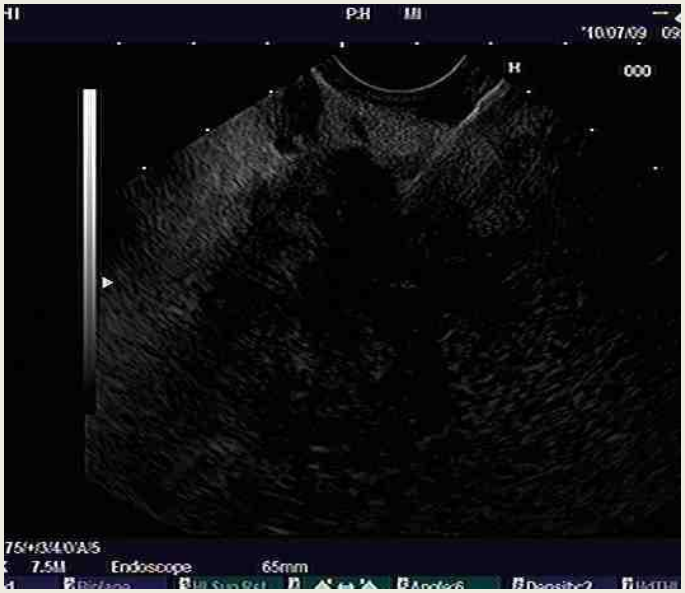
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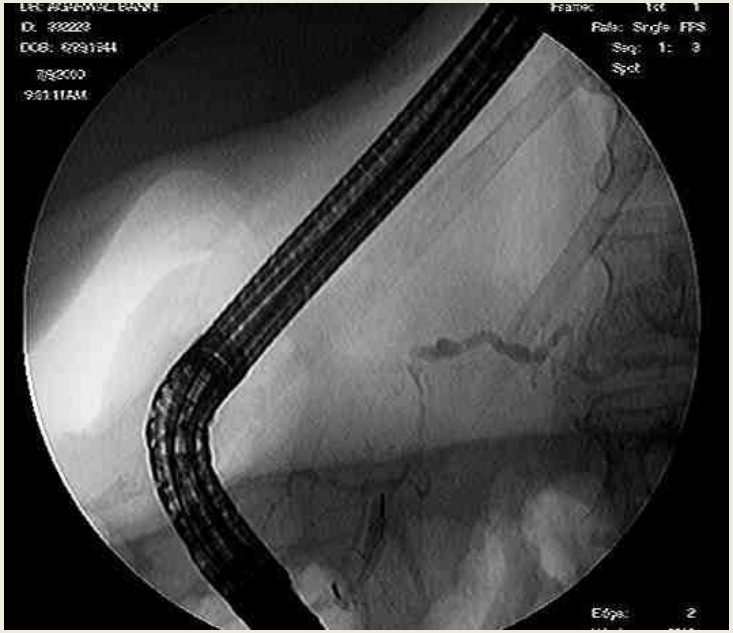
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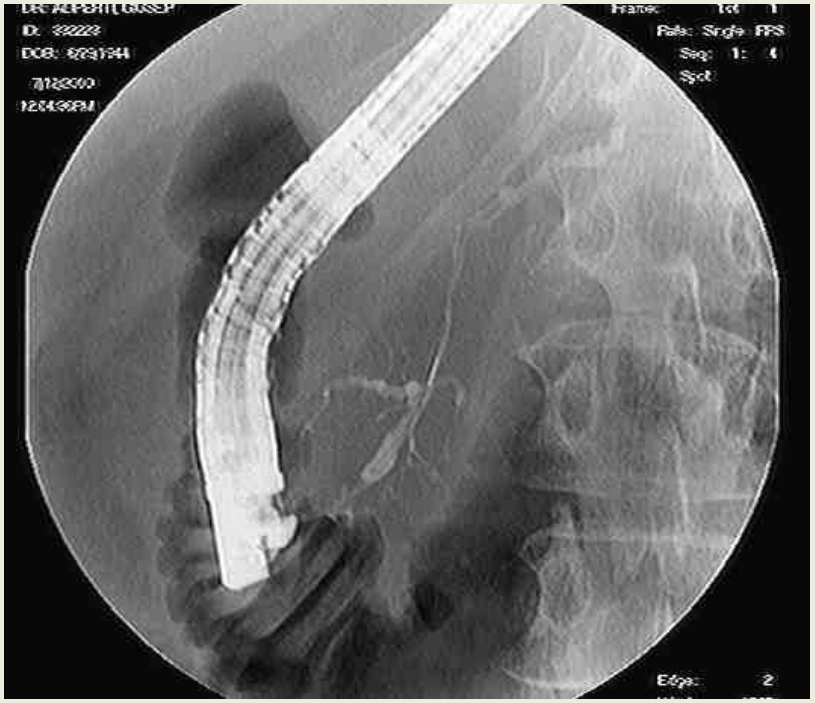
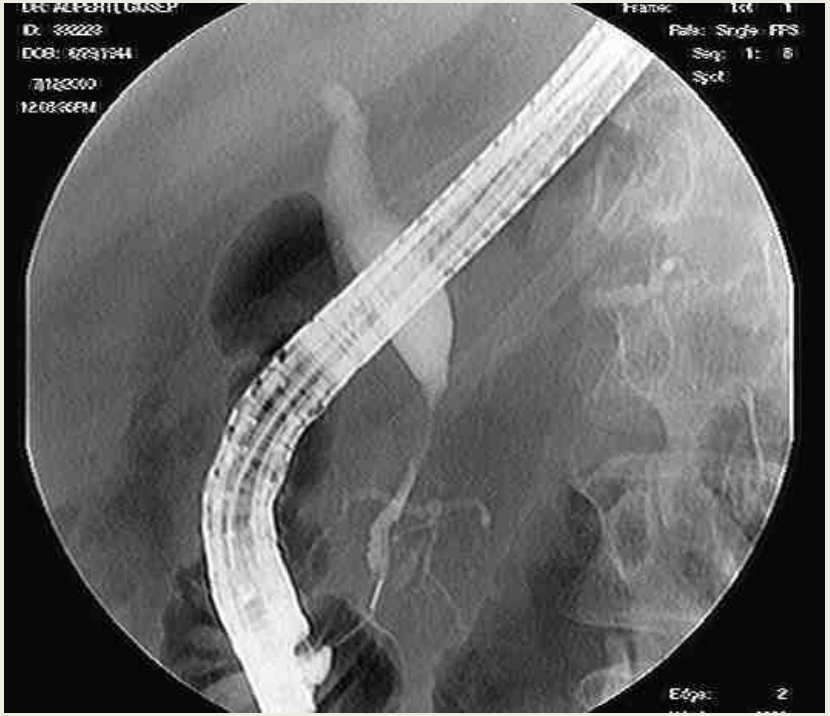
- Patient develops obstructive jaundice 5 days later





- The patient undergoes Whipple resection for presumed pancreatic cancer
- Surgical pathology
  - Focal chronic pancreatitis with intense fibrosis
  - No pathologic evidence of malignancy
- Serum IgG4 levels (done after surgery)
  - Not elevated

What is true regarding this patient

1. The patient has focal chronic pancreatitis and should be considered cured now.
2. This patient should not have been operated and should have received steroid treatment for focal autoimmune pancreatitis
3. This lesion is likely well differentiated pancreatic adenocarcinoma and pathology is false negative.
4. Molecular analysis should be considered to determine the final diagnosis of the pancreatic lesion.

Rob Hawes

- Do you think that the pathologic diagnosis in this patient is consistent with the clinical presentation

Fernando Del Castillo

- Do you think that Whipple resection was appropriate in this patient
- How often does focal chronic pancreatitis present like in this patient

Robert Wolff

- How often is focal chronic pancreatitis misdiagnosed as pancreatic cancer and vice versa in pathology resection specimens

- Do you foresee a role for molecular analysis for final diagnosis in patients where there is major discordance between the pathologic and clinical diagnosis

Thank You

(End of Session IV)