Management of Pancreato-biliary Malignancy

Moderators:

Giuseppe Aliperti, MD
Paul Schultz, MD
<table>
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<th>Role</th>
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<tr>
<td>Pancreatic Surgeon:</td>
<td>Douglas Evans, MD</td>
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<td></td>
<td>Hamill Foundation Distinguished Professor of Surgery</td>
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<td>Chief, Endocrine and Pancreatic Surgery</td>
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<td>MD Anderson Cancer Center</td>
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<td>Hepatobiliary Surgeon:</td>
<td>Micheal Choti, MD, MBA</td>
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<td>The Jacob C. Handelsman Professor of Surgery</td>
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<td></td>
<td>Chief, Handelsman Division of Surgical Oncology</td>
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<td>Johns Hopkins Medical Institute</td>
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<td>Oncologists:</td>
<td>Robert Wolff, MD</td>
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<td>Associate Professor, GI medical Oncology</td>
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<td>Deputy Head, Division of Cancer Medicine</td>
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<td>Endosonographer:</td>
<td>Frank Gress, MD</td>
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<td>Professor of Medicine</td>
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<td>Chief, Division of Gastroenterology and Hepatology</td>
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<td>SUNY Downstate Medical Center</td>
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<td>ERCPist:</td>
<td>David Carr-Locke, FRCP</td>
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<td>Director, The Endoscopy Institute</td>
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<td>Associate Professor, Division of Gastroenterology</td>
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<td>Brigham and Women’s Hospital</td>
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Surgery for pancreatic cancers

Douglas Evans 12 minute

- What are the criteria for unresectability?

- What is a borderline resectable tumor
  - Management of borderline resectable tumors
  - Vascular resection and reconstruction - when is it worth it?

- Resectable tumors in patients who are poor surgical candidates
  - Risk-benefit analysis

- Role of surgeon in unresectable tumors

- What are objective criteria for identifying adequate/good surgical results?
Surgery for Cholangiocarcinoma:
Michael Choti 12 mins

- How to identify unresectable tumors
- Management of surgically unresectable tumors
- Resectable tumors in bad locations
- Resectable tumors in bad operative candidates
- Suspected cholangiocarcinomas without definitive tissue diagnosis
  - When the tumor seems resectable
  - When the tumor appears unresectable
Medical management of pancreato-biliary cancers:

Robert Wolff  12 mins

- **Pre-op chemoradiation**
  - All potentially resectable tumors or only borderline resectable tumors

- **Post-operative chemoradiation after**
  - R0 resection (negative margins)
  - R1 resection (microscopic positive margins)
  - R2 resection (macroscopic positive margins)

- **Palliative chemoradiation**
  - What is the role and benefit

- **Chemotherapy/chemoXRT non-responders**
  - Role of second and third line therapies
  - Benefits vs toxicity
EUS in management of pancreato-biliary cancers:
Frank Gress 12 mins

- Staging pancreatic cancers with EUS
  - Where and how does it help?

- Staging cholangiocarcinomas with EUS
  - Role of intraductal US

- Therapeutic EUS
  - Pain management with Celiac plexus block
  - Intratumoral injection of therapeutic agents
  - Fiducial placement for radiotherapy

- Recurrent cancer after Whipple
  - Role of EUS
Interventional Endoscopy in management of Pancreato-biliary Cancers:
David Carr-Locke 12 mins

- Palliation of jaundice
  - Cholangiocarcinoma
    - Drain one side or both sides
    - Plastic vs metal stents
  - Pancreatic cancers
    - Plastic vs metal stents

- Timing of stent change in unresectable tumors
  - When stent is occluded or at fixed intervals

- Brachytherapy for cholangioCa

- Gastric outlet obstruction
  - Stent placement vs gastric bypass
  - Timing of stent placement

- Role of G-J tube for nutrition
  - Do they help or they increase morbidity and mortality
Case 1

- A 59 year old woman undergoes a R0 Whipple resection of her pancreatic cancer.
- Receives post-operative chemo-radiation
- Patient doing well
AQ1. Should the patient have an active or passive post-treatment follow-up

1. Active follow-up
2. Passive follow-up
Comments from the faculty
AQ2. What are appropriate tests for follow-up

1. CA19-9
2. CT abdomen
3. CT pelvis
4. PET scan
5. 1 and 2 only
6. All of the above
Comments from the faculty
<table>
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<th>CA 19-9 Ag</th>
<th>Result</th>
<th>Expected Units</th>
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<td></td>
<td>3.9</td>
<td>0.0 - 35.0 Units/ml</td>
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- Minimal soft tissue infiltration at surgical clips
- Unchanged at 3 months and 6 months
AQ3. 9 months after surgery,

- her CA19-9 levels increase to 60 ng/ml and

- then 3 months later to 95 ng/ml.

Appropriate next test in this patient would be

1. CT scan- chest/abdomen/pelvis
2. MRI scan
3. PET scan
4. EUS-FNA
5. EGD
Comments from the faculty
Soft tissue at surgical bed with main PV narrowing
**AQ4.** PET scan shows hot spot in the bed of pancreatic head. Appropriate next test would be

1. EUS-FNA
2. CT-guided FNA
3. Repeat CT scan in 6-12 weeks
4. Treat empirically with second line chemotherapy
5. None of the above
Comments from the faculty
AQ5. CT guided FNA shows recurrent adenocarcinoma. Appropriate next step in management would be

1. Refer to surgery for removal of recurrent tumor
2. Radiotherapy
3. 2nd line Chemotherapy±Radiation
4. Hospice
Comments from the faculty
Question to all faculty

- What kind of follow-up is appropriate in patients with pancreatic cancer after treatment
  - Are there any situations where intensive follow-up is worthwhile and
  - Which are those clinical situations
David Carr-Locke

- Obstructive jaundice in patients after Whipple’s resection for pancreatic cancer
  - Are attempts at ERCP worth the effort?
  - What kind of stents to use for drainage?
  - Role of double balloon enteroscope?
Case 2

- 65 year man presents with new onset obstructive jaundice

- **ERCP**
  - a mid CBD stricture. s/p biliary stent placement

- **EUS-FNA**
  - 2 cm focal mass lesion in relation to mid CBD
  - Cytology atypical cells with lots of inflammation.
    - However not diagnostic for cancer
AQ6. Appropriate next step in the management of this patient is

1. Surgical exploration
2. Follow up imaging in 6 weeks
Comments from the faculty
Frank Gress

- What is the value of EUS-FNA in diagnosis of biliary strictures
  - Is it useful in ruling out unresectable cancers
  - Are there any benign etiologies that are easily and reliably diagnosed by EUS-FNA or biliary Intraductal Ultrasound (biliary IDUS)
Patient is taken for surgery.

During surgery

- the diagnosis of cancer is confirmed and
- malignant periportal lymph nodes are also encountered.

**AQ7.** Appropriate next step would be

1. Proceed with surgery and remove the tumor and lymph nodes
2. Abandon resection of tumor and close the abdomen
Comments from the faculty
AQ8. Surgeon decides against proceeding with resection and closes abdomen.

Further management of this patient should involve placement of a metal biliary stent and:
1. No further therapy
2. Chemoradiation
3. Chemotherapy alone
4. Radiation alone
Comments from the faculty
In patients with hilar/perihilar cholangiocarcinoma, how do you choose between

- surgical bypass and endoscopic stent placement for biliary drainage
AQ9. Patient is started on chemoXRT and has good response.

Should this patient be re-evaluated for another attempt at surgical resection

1. Yes
2. No
Comments from the faculty
**AQ10.** Active follow-up in patients with cholangio-carcinoma is recommended in

1. Resectable tumor that is removed with R0 resection
2. Following R1 and R2 resection
3. Unresectable tumor managed with chemoXRT
4. None of the above
Comments from the faculty
Closing remarks from each panelist