UCCH Pathway

UCCH Guideline
Biliary Tract Cancer

Version April/2023

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Cholangiocellular Carcinoma
Version 03, April/2023

according to WHO classification 2016

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Implemented	June/2019
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Next planned review	May/ 2025

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

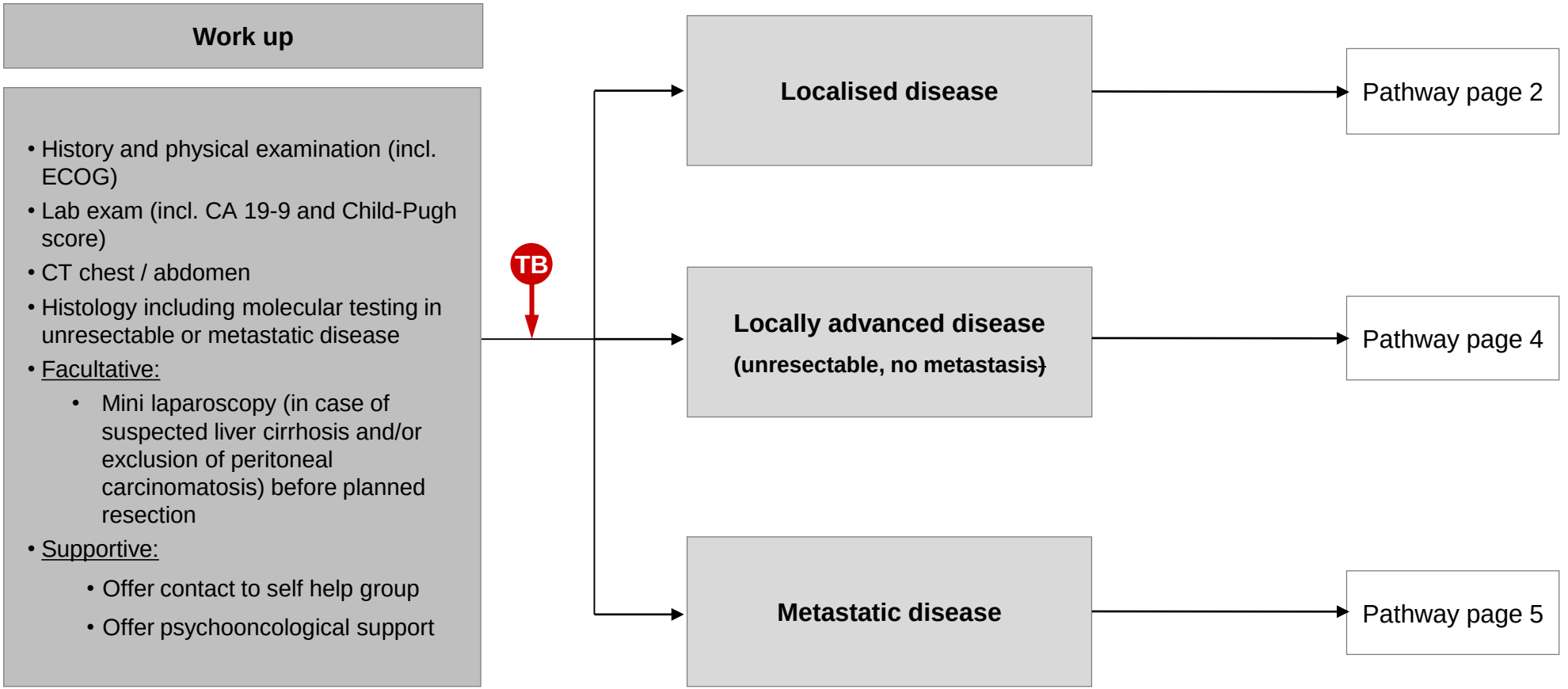
= Clinical trial

= Supportive measure

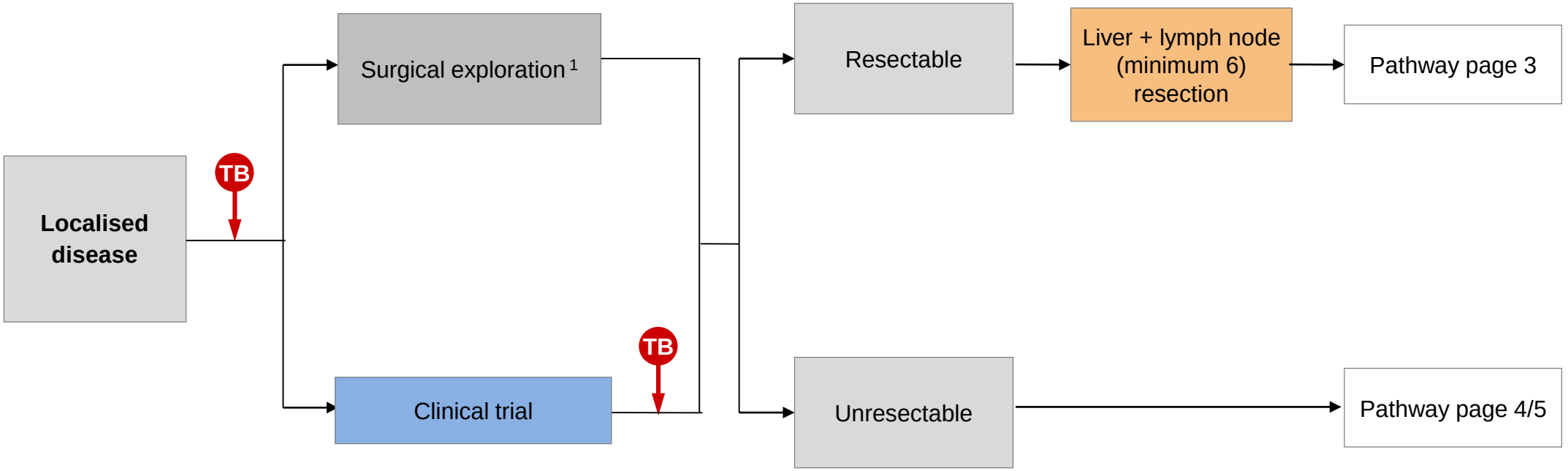
= Referral

= Tumorboard (including post tumorboard interaction with patient that follows the principles of shared decision-making)

Pathway: Biliary Tract Cancer

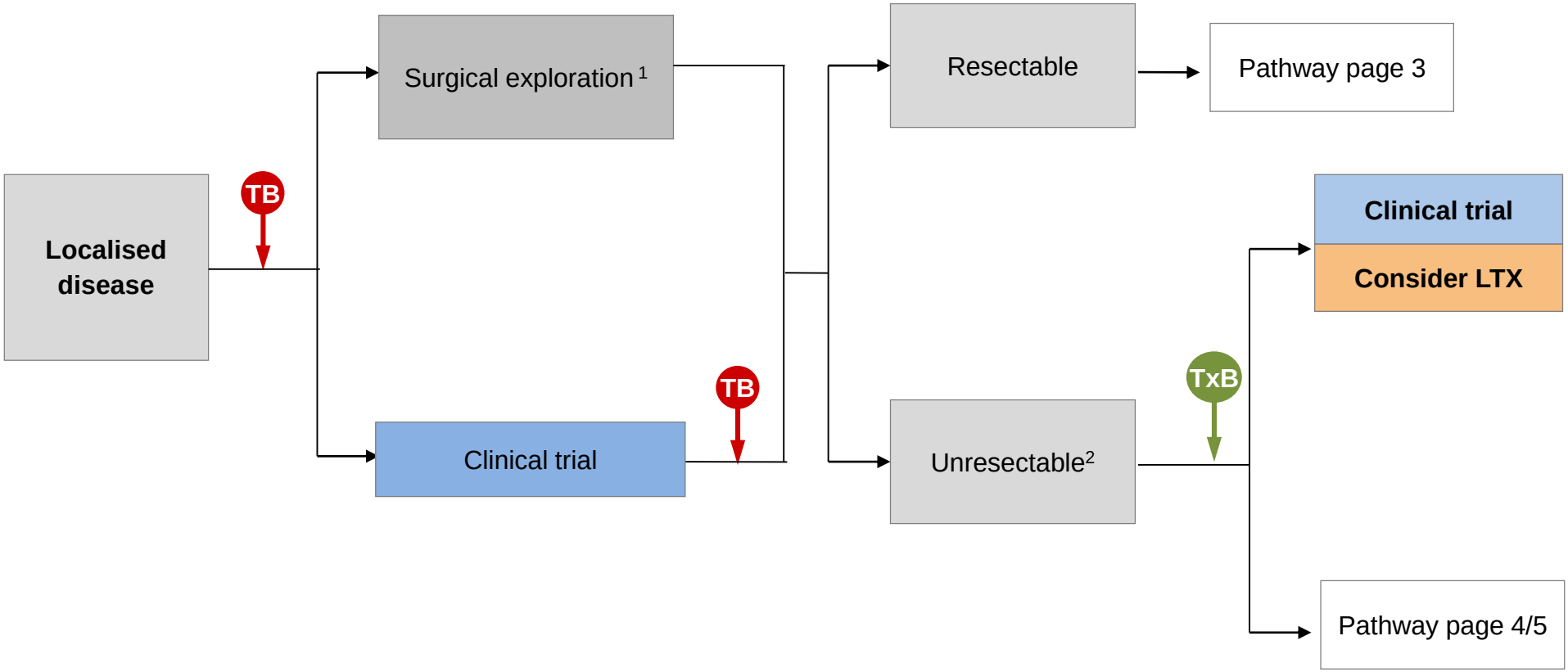


Pathway page 2.1. intrahepatic BTC (iCCA): Localized disease



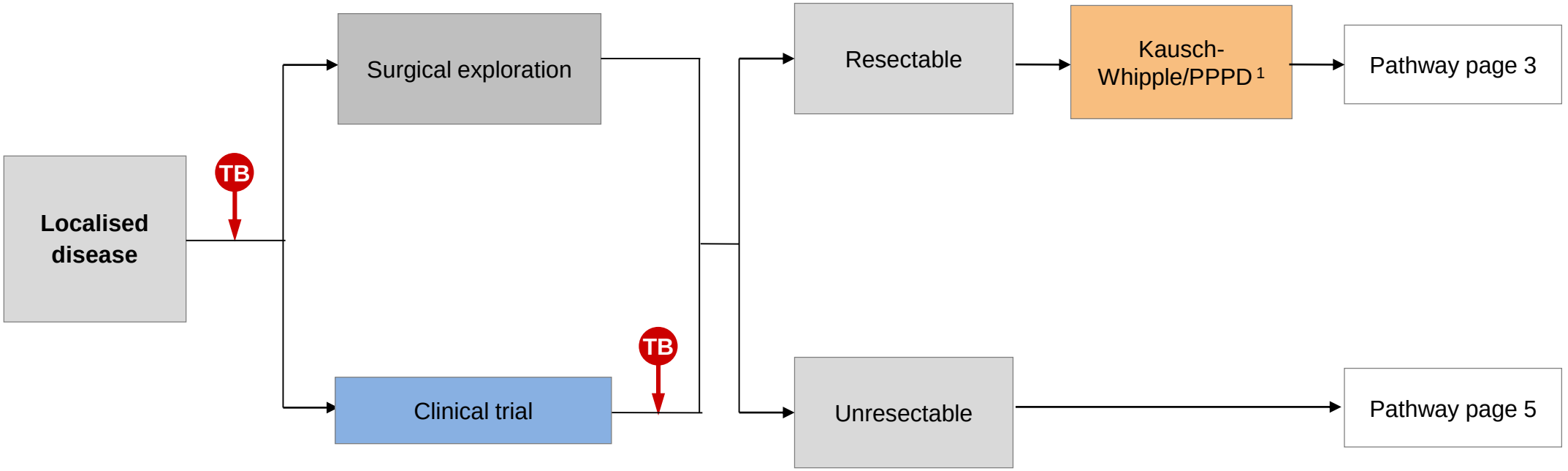
[1] Surgical exploration: bilirubin <5 mg/dl, sufficient future liver remnant

Pathway page 2.2. extrahepatic proximal BTC (perhilar CCA): Localized disease



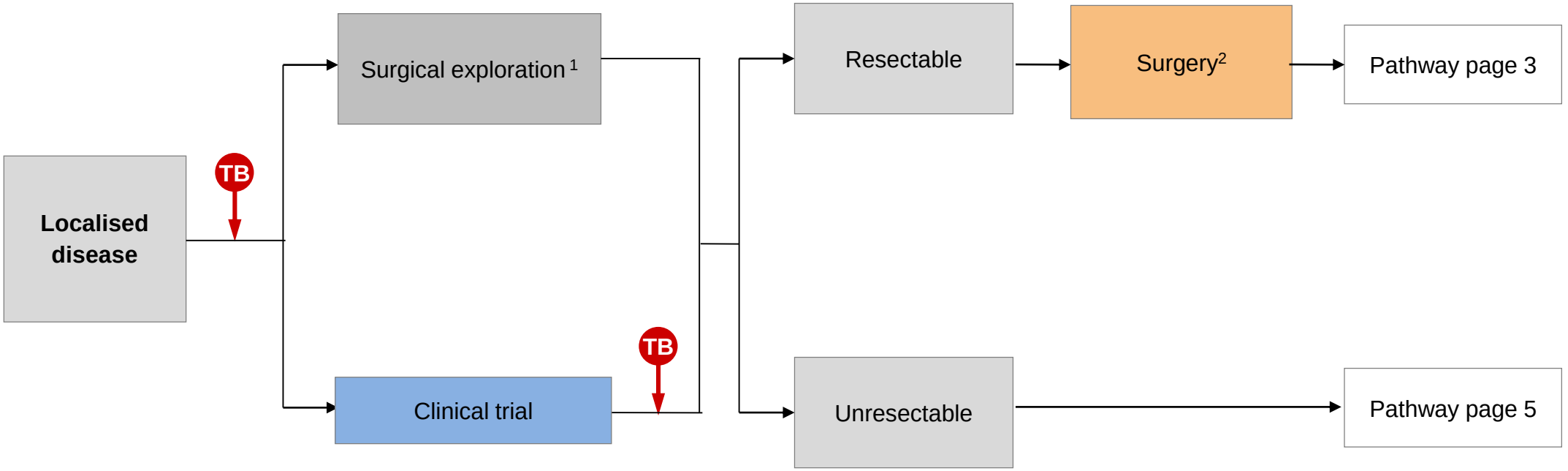
[1] Surgical exploration: bilirubin <5 mg/dl, sufficient future liver remnant
[2] Bismuth IV not considered as obligat contraindication

Pathway page 2.3. extrahepatic distal BTC: Localized disease



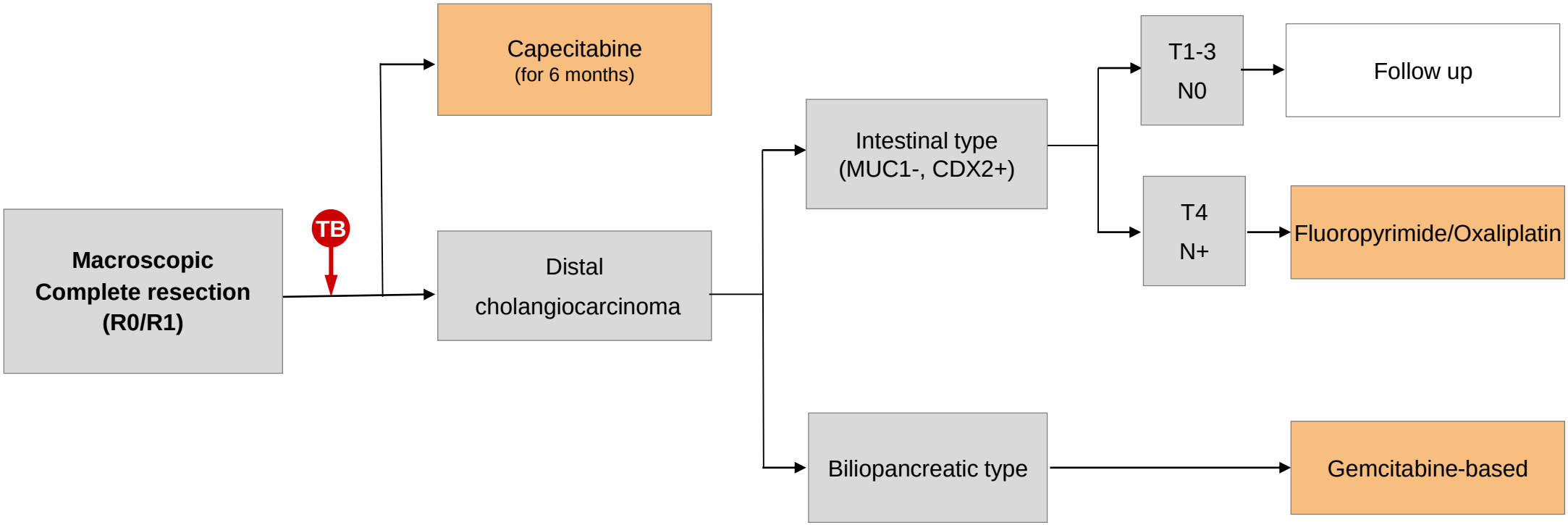
[1] Prefer Whipple Operation instead of only bile duct resection

Pathway page 2.4. gall bladder cancer: Localized disease

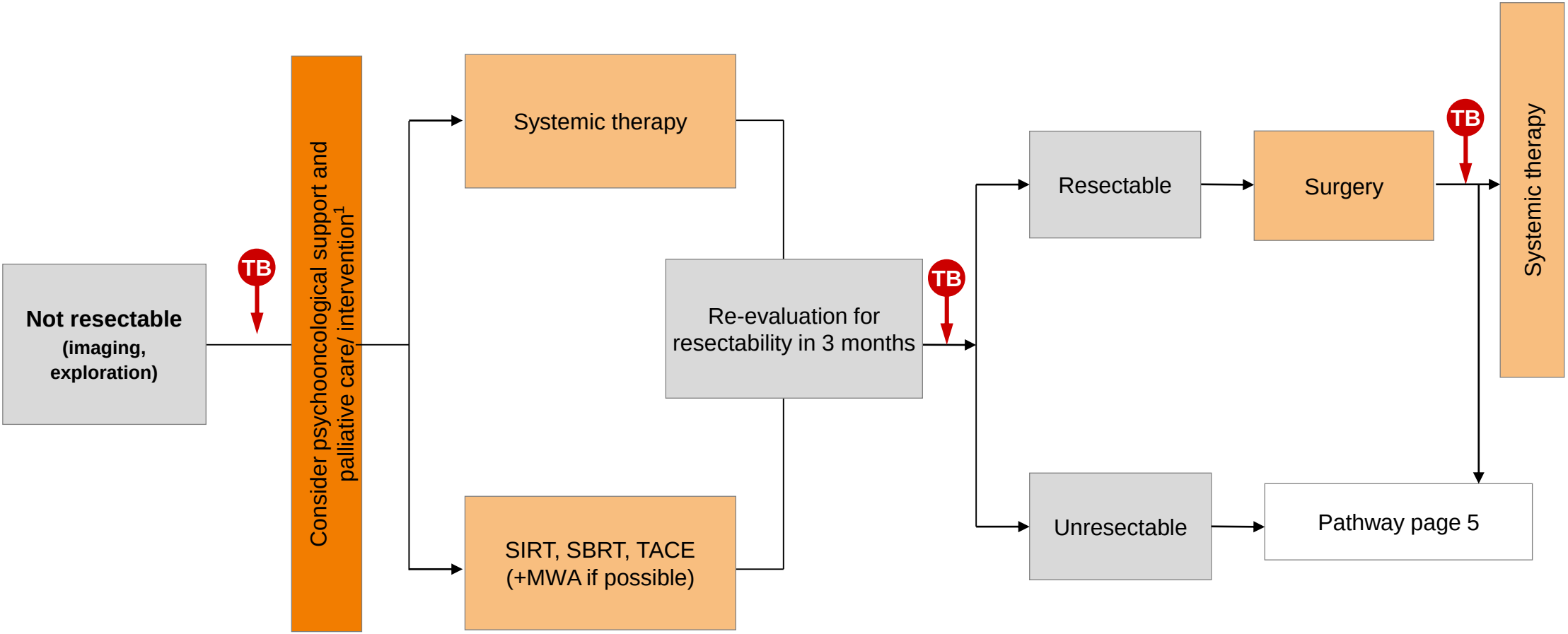


[1] In patients with incidental GBCA, surgical exploration in T1b and above
[2] Liver resection with cholecyzstectomy en bloc, bile duct resection only when cystic duct is involved

Pathway page 3: Adjuvant therapy



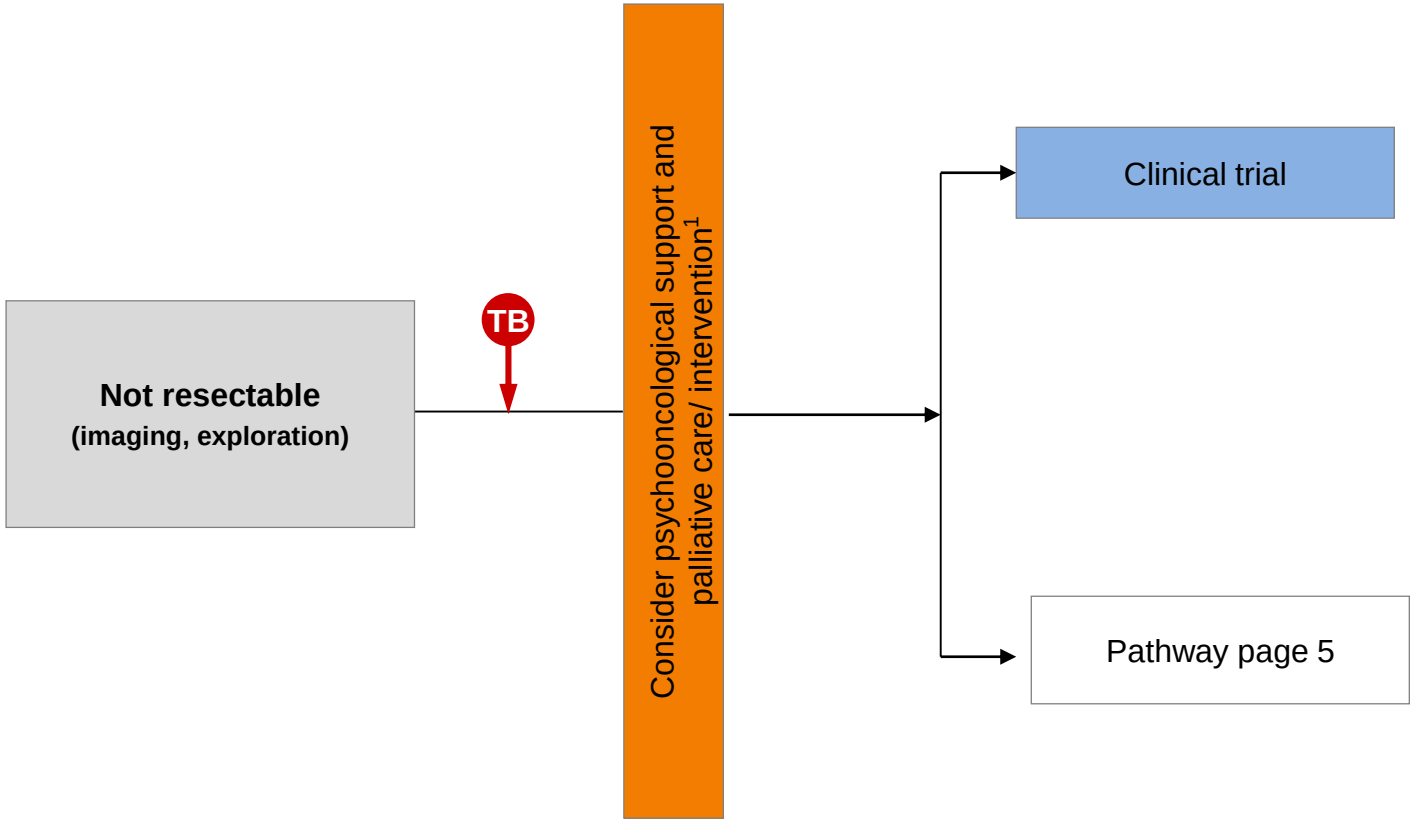
Pathway page 4.1.iCCA: Locally advanced/ non-metastatic



SIRT Selective internal radiotherapy TACE Trans-arterial chemoembolization MWA Microwave ablation SBRT Stereotactic body radiation therapy

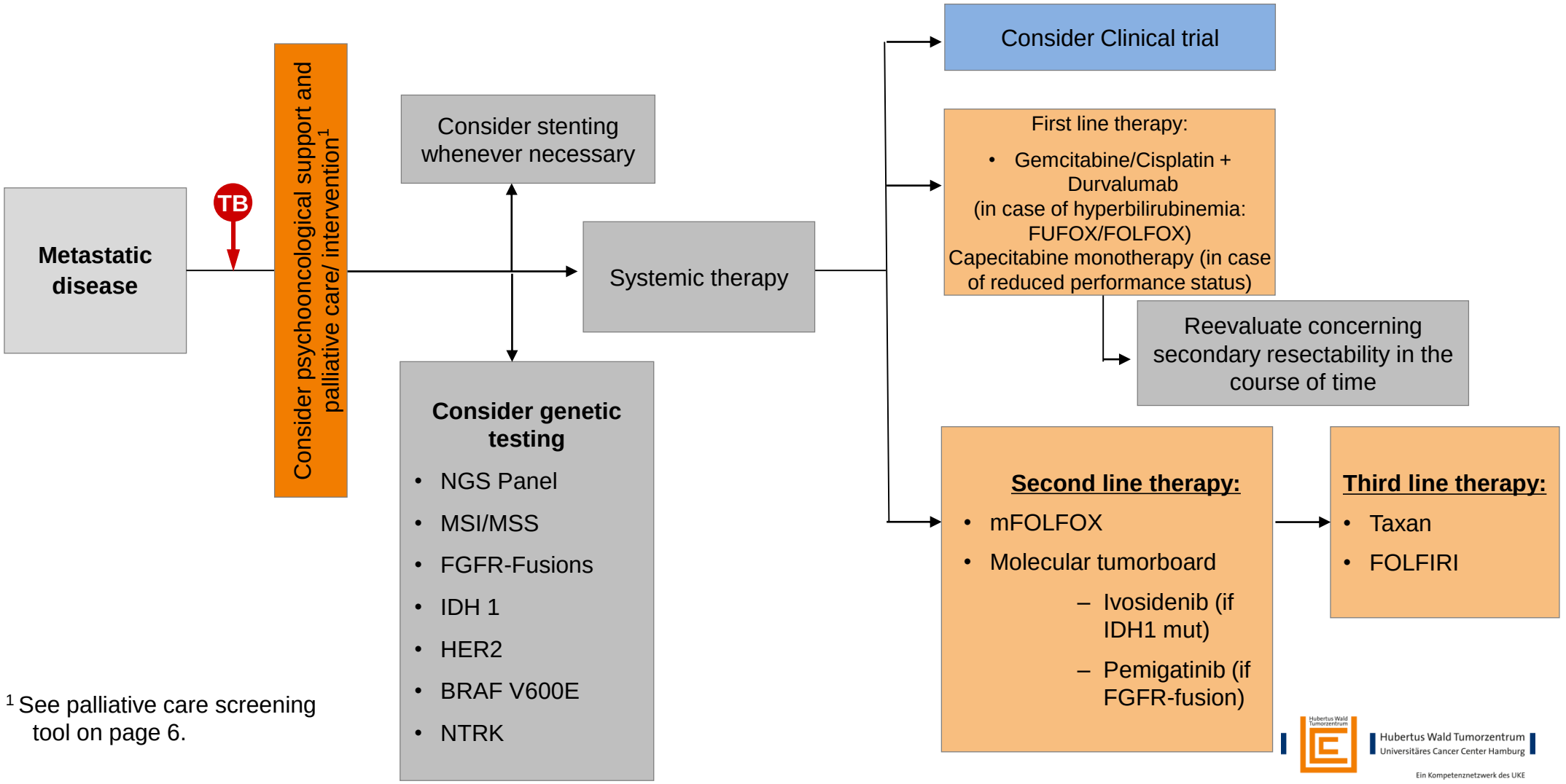
[1] See palliative care screening tool on page 6.

Pathway page 4.2. extrahepatic BTC and gallbladder CA: Locally advanced/ non-metastatic



[1] See palliative care screening tool on page 6.

Pathway page 5: Metastatic disease/ non-resectable



[1] See palliative care screening tool on page 6.

Page 7: Follow up

Offer contact to psychooncology and/or self help group whenever necessary

1.) Local disease / Surgery or ablative :

Every 3 months for 2 years, afterwards every 6 months for 3 years. Minimal follow-up of 5 years

- Clinical presentation
- Laboratory exam
- Contrast enhanced CT or MRI
- Chest imaging if clinically indicated or every 6 months

2.) Metastatic disease / Systemic treatment:

Every 3 months or if clinically indicated

- Clinical presentation
- Laboratory exam
- Abdominal imaging
- Chest imaging (only in patients with chest lesions, otherwise every 6 months)

Page 6: Palliative care screening tool

Screening items			Points
1.		• Presence of metastatic or locally advanced cancer	**2**
2.		• ECOG score (functional status score, performance status)	**0-4**
3.		• Presence of one or more serious complications of advanced cancer usually associated with a prognosis of < 12 months (e.g. brain metastases, hypercalcemia, delirium, spinal cord compression, cachexia)	**1**
4.		• Presence of one or more serious comorbid diseases also associated with poor prognosis (e.g. moderate-severe COPD or CHF, dementia, AIDS, end stage renal failure end stage liver cirrhosis)	**1**
5.		• Presence of palliative care problems	**1**
	a.	• Symptoms uncontrolled by standard approaches	**1**
	b.	• Moderate to severe distress in patient or family, related to cancer diagnosis or therapy (personal targets and expectations, educational and informational requirements, cultural factors)	**1**
	c.	• Patient/family requests palliative care consult	**1**
	d.	• Team needs assistance with complex decision making or determing goals of care (benefit/side effects of treatment)	**1**
	e.	• Instable or deficient network especially for emergency situation or 24-h care	**1**

A total of > 5 points signalizes need for supportive palliative care

According to Glare et al. (2011); NCCN Clinical Practice guidelines in Oncology 2015