UCCH Pathway

UCCH Guideline
Pancreatic Carcinoma

Version May/2020

Hubertus Wald Tumorzentrum
Universitäres Cancer Center Hamburg
Ein Kompetenznetzwerk des UKE

Guideline Pancreatic Carcinoma

Version 06, May/2020

according to TNM classification 7th edition

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Implemented	Apr/2011
Revised	May/2013, May/2015, Oct/2017, Mar/2019, May 2020
Next planned review	May/2022

Legend of Colours

= Therapeutic procedure

= Clinical or diagnostical condition

= Diagnostic procedure

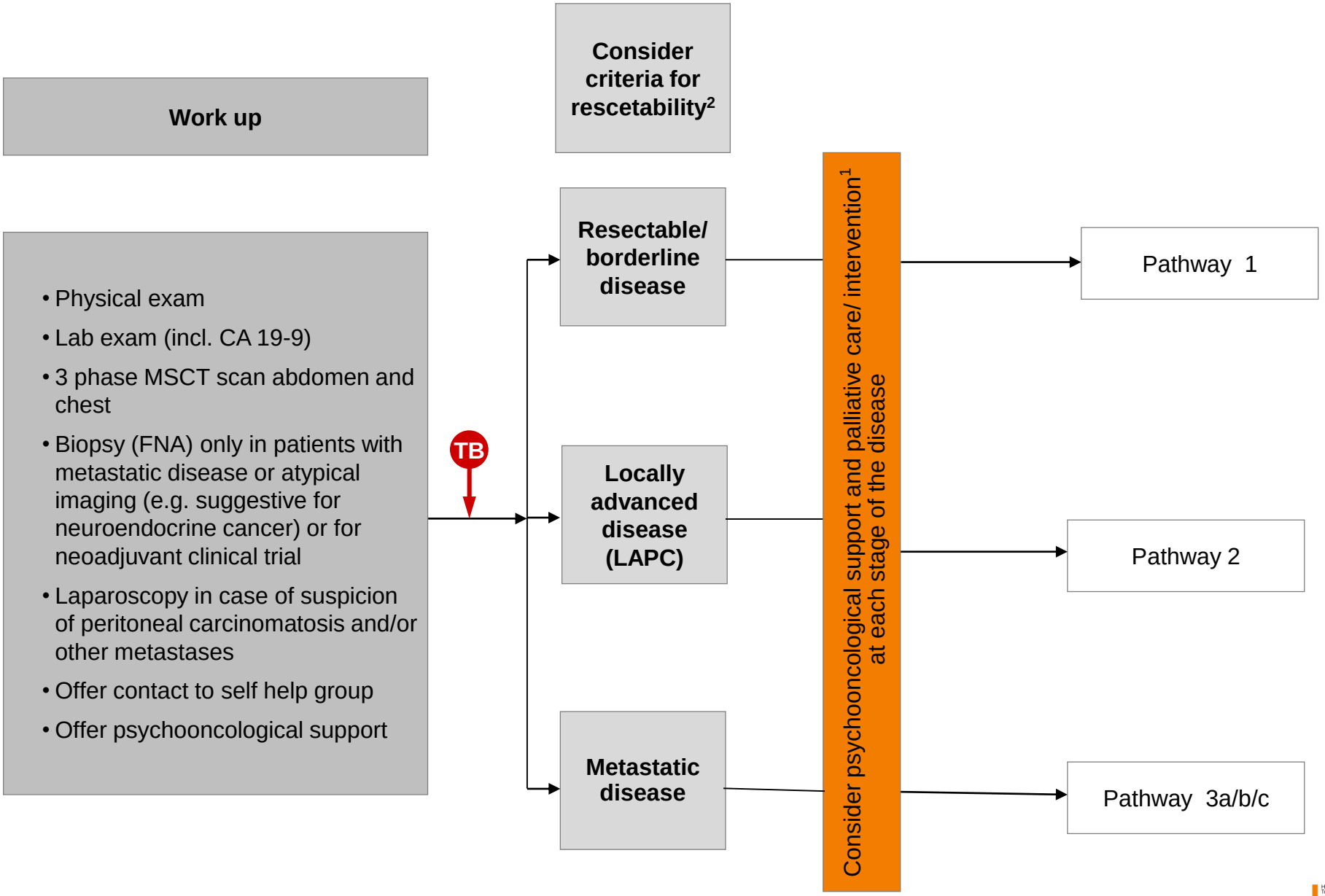
= Clinical trial

= Supportive measure

= Referral

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

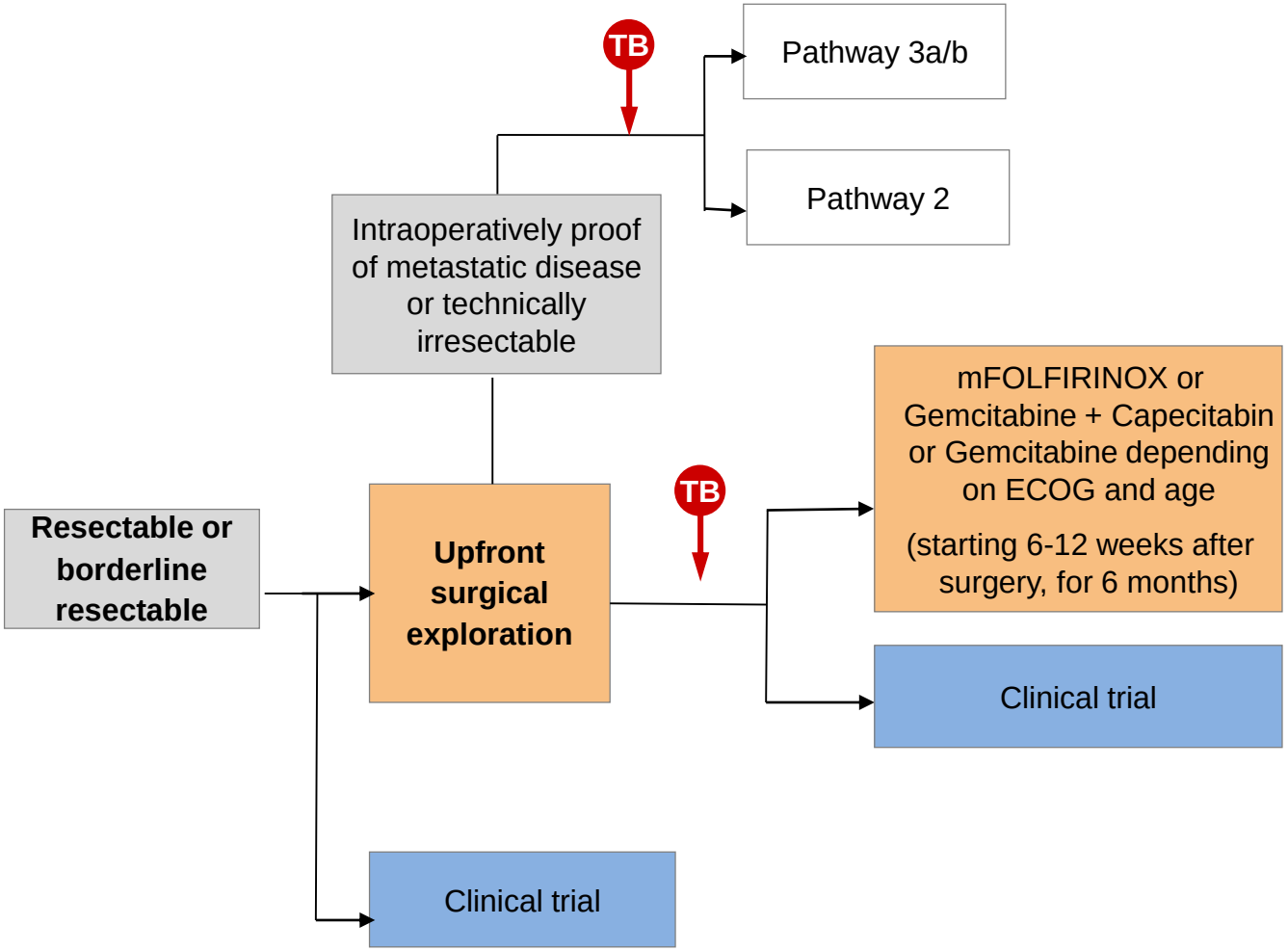
Pathway: Pancreatic Carcinoma



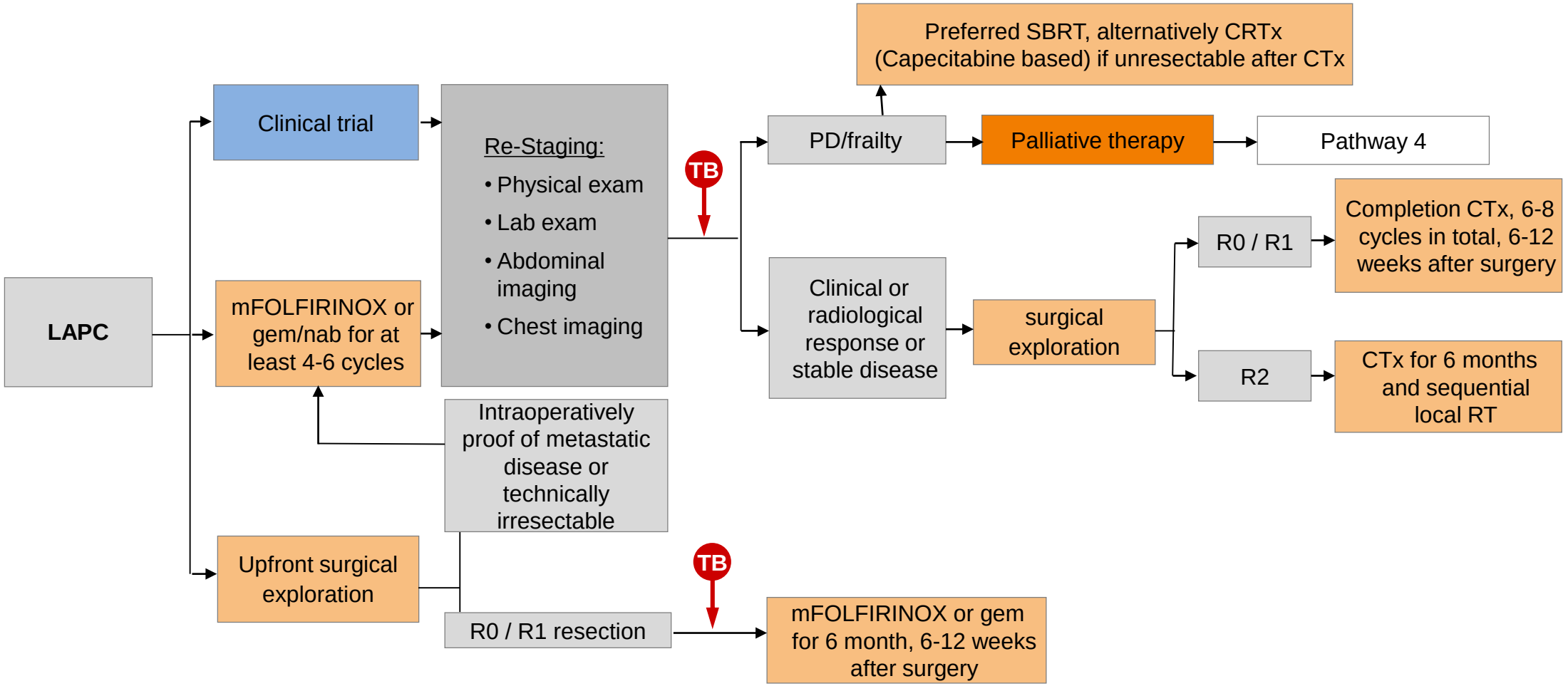
[1]See palliative care screening tool on page 8

[2] for details refer to page 5

Pathway 1: Resectable or borderline resectable

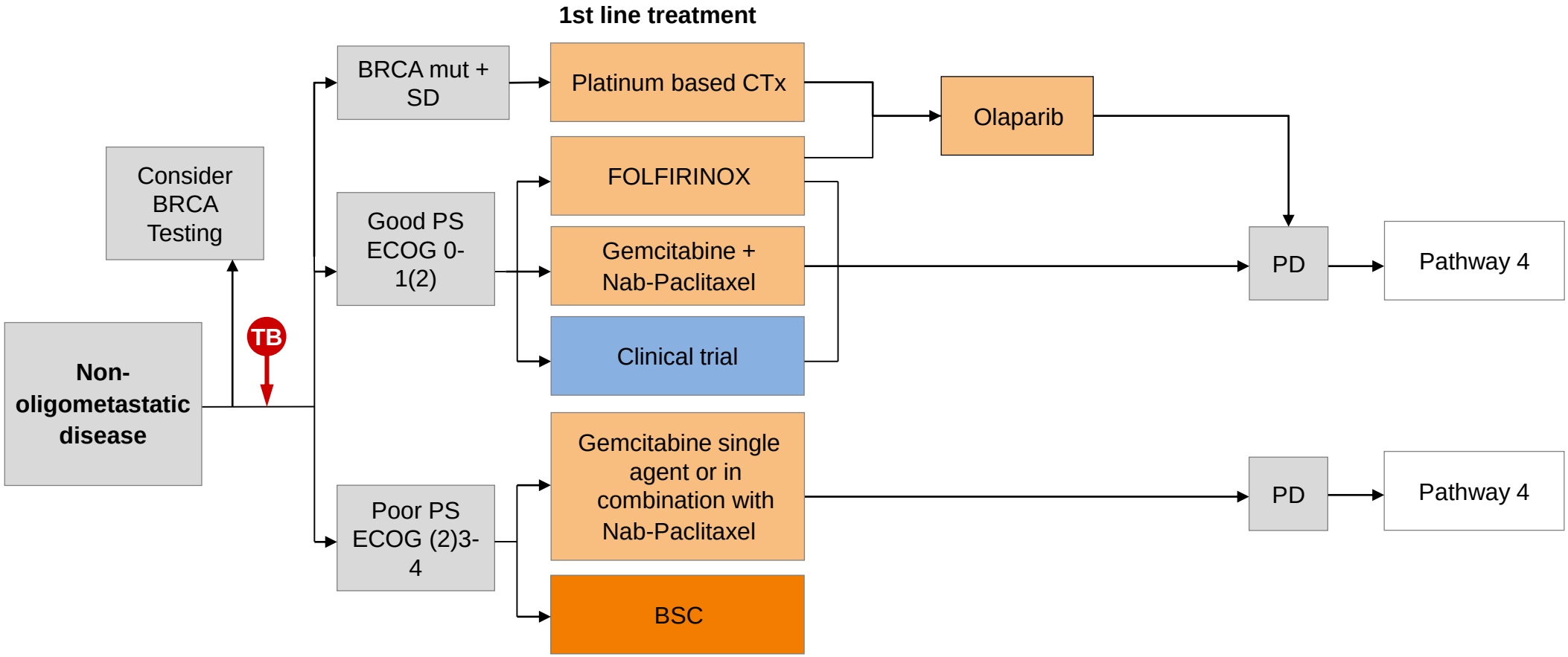


Pathway 2: locally advanced pancreatic cancer (LAPC)



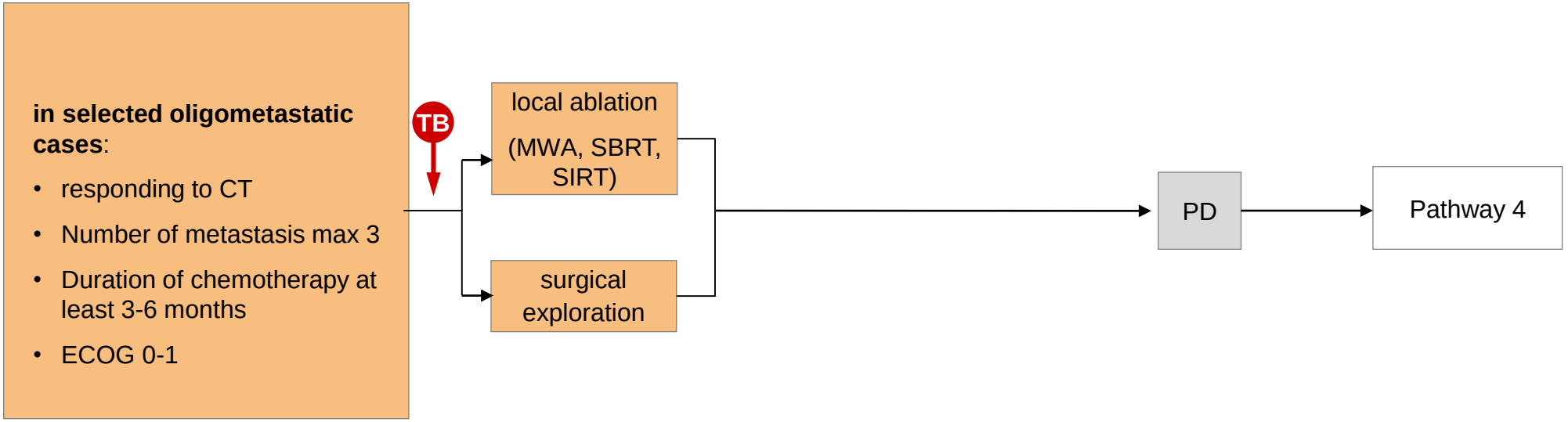
CRTxChemoradiation, CTx Chemotherapy, PD Progressive disease, SBRT Stereotactic body radiotherapy

Pathway 3a: metastatic disease, palliative treatment



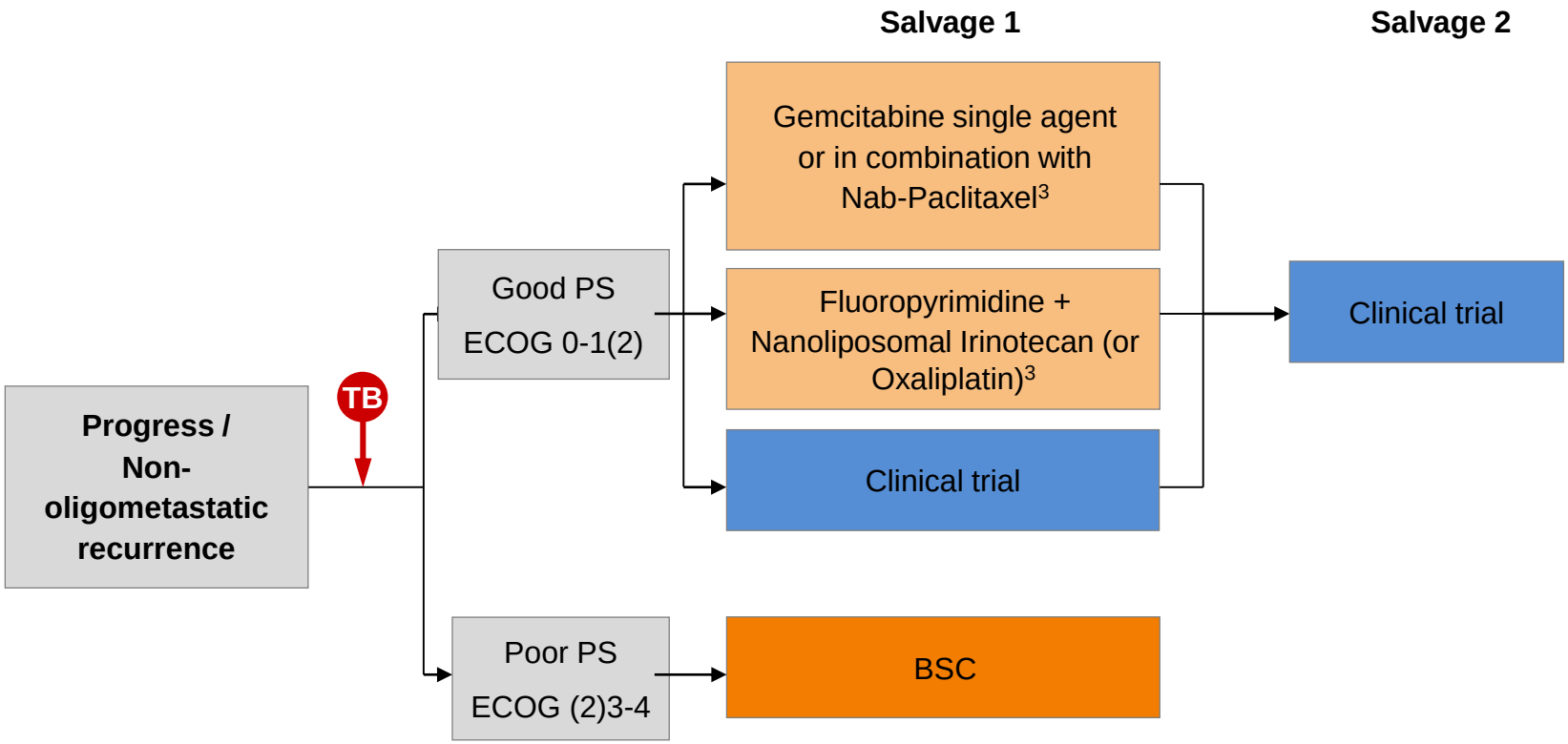
PS Performance Status, BSC Best Supportive Care, SD Stable disease, PD Progressive disease, CTx Chemotherapy

Pathway 3b: oligometastatic disease



PD Progressive disease, SBRT Stereotactic body radiotherapy, SIRT selective internal radiotherapy, MWA microwave ablation

Pathway 4: Salvage therapy



PS Performance Status, BSC Best Supportive Care

[3]Depending on first line therapy: sequence of FOLFIRINOX, followed by Gemcitabine + NabPaclitaxel or initial Gem/NabPac followed by Fluoropyrimidine +Nanoliposomal Irinotecan (or Oxaliplatin) or vice versa

Page 5: Radiologic criteria defining resectability status

pancreatic "traffic light"	Criteria	Status
SMV/PV	<180°	
	>180° up to complete occlusion **without** crossing inferior duodenal border	
	>180° up to complete occlusion **with** crossing inferior duodenal border	
SMA	no contact	
	<180°, no stenosis, no deformation	
	>180°	
CA	no contact	
	<180°, no stenosis, no deformation	
	>180°	
Hepatica communis	no contact	
	tumor contact without showing tumor contact of the PHA and/or CA.	
	tumor contact/invasion showing tumor contact/invasion of the PHA and/or CA.	

cumulative result	
Resectable	
Borderline resectabel venous	
Borderline resectabel arterial	
locally advanced venous	
lokally advanced arterial	

Based on IAP Consensus

Page 6: Follow up:

Every three months or if clinically indicated

- Clinical presentation
- Laboratory exam (including CA 19-9)
- Abdominal imaging (Ultrasound or CT)
- Chest imaging

- Offer contact to self-help group and psychooncological support whenever necessary

Page 7: Best supportive care / palliative treatment

- Consider nutrition counseling, psychological counseling

Biliary obstruction

- Endoscopic biliary stent
- Percutaneous biliary drainage with subsequent internalization
- Open biliary-enteric bypass

Gastric outlet obstruction

- Gastrojejunostomy +/- J-tube
- Enteral stent
- PEG tube

Tumor associated pain

- Analgetica (WHO)
- Palliative chemoradiation
- Plexus neurolysis

Pancreatic insufficiency

- Pancreatic enzyme replacement

Page 8: 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