Referral and management guidelines for pancreatic and related cancers

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Introduction

These guidelines were revised and expanded during 2011 in response to peer review visits to the West Midlands and routine governance processes. The West Midlands Supra network Hepatobiliary Group is responsible for promoting standards and services for HPB cancers for the whole of the West Midlands. This encompasses multiple Cancer Networks, 3 specialist centres for HPB and a large number of Trusts. Representation is received from all these parties so that guidance can be most appropriate and shared for all patients across all sites.

In accordance with the Improving Outcomes Guidance for Upper GI all patients with suspected pancreatic cancer should be discussed with a member of the specialist MDT and this should be documented in the notes.

This guidance is intended principally for primary care and hospital staff who refer to HPB cancer centres in order to clarify which patients should be considered for referral for clinical review and to expedite that process.

In particular, it is hoped to:

- Clarify which patients should be considered for referral
- Speed the referral process
- Clarify issues around stenting
- Focus issues of palliative care

Clinical presentations will be discussed as jaundice or not jaundiced.

THE REFERRAL PROCESS

JAUNDICED PATIENTS

This involves mostly patients with pancreatic cancer and also biliary tract cancer. In primary care, it is important to avoid delay. It is usually not helpful to perform any investigations, with the possible exception of biochemical liver function, unless there is reason to be confident of a non malignant diagnosis.

Patients should be referred to the local hospital's jaundice clinic or equivalent within days. This should be done on an outpatient basis unless the patient is too ill.

In secondary Care

Routine assessment will include:

- History, examination, biochemical liver function, Ca 19.9 and clotting studies, prescribe vitamin K
- Ultrasound scan

- Urgent CT chest/abdomen/pelvis , if biliary obstruction not clearly due to stones or any suspicion of malignancy. Use pancreatic protocol (Biphasic CT Abdomen with i.v contrast + Oral waterload. Plan for review at local MDT but parallel referral to specialist MDT if appropriate to speed decision making.

Protocol Name	**UPPER GI -STAGING PANCREATIC CANCER**
Type of Oral Prep:	750 mls Water (drink continuously for 20mins preceeding scan)
Additional Prep:	Remove artefacts
Cannula Type:	18 g green venflon
IV Contrast:	2mls (Niopam 300) /kg (max 120mls)
Flow Rate:	3 ml / sec
Patient Position:	Supine
TOPOGRAM	Diaphragms to below symph
PROTOCOL :	
Dual phase 1. Pancreatic phase upper abdomen at 28 sec post peak aortic (abdominal) enhancement (AO +28 sec)-ROI trigger D – C (diaphragm to crests) 2. Venous Phase D – S (diaphragm to symph)	
Refer to protocol description on Radiographer IR(ME)R protocoling plus non IR(ME)R protocols	
Additional Information:	
Coronal reconstructions of arterial phase. Same field of view for each sequence. NB. This is for pancreatic cancer only, there is a separate **early arterial phase neuroendocrine PANCREATIC protocol**	

Referral to tertiary centre This should be done as soon as possible to an appropriate member of that centre's team, and initially consist of PACS transfer of CT images and patient information including all biochemistry. The centre's MDT will respond with an opinion within days and subsequently see the patient if appropriate and requested. This might involve an inter-hospital transfer of the patient's data. The patient needs to be informed of the diagnosis, about referral to the specialist centre and the GP updated.

The overall intention is to speed the decision making process about potential surgery and stenting. This may involve 'fast tracking' with the tertiary centre without waiting for formal MDT discussion locally.

Criteria for referral to the Specialist MDT through the TWW route
Jaundice caused by potentially resectable tumour:

- defined by absence of obvious metastases
- questions of lymphadenopathy or vascular involvement should not normally prevent referral
- the initial referral will be by PACS transfer, so patients will not be inconvenienced

Patient fitness:

- Age usually under around 80 dependant upon co-morbidities
- Good functional status
- Uncertainty to be assessed by tertiary centre

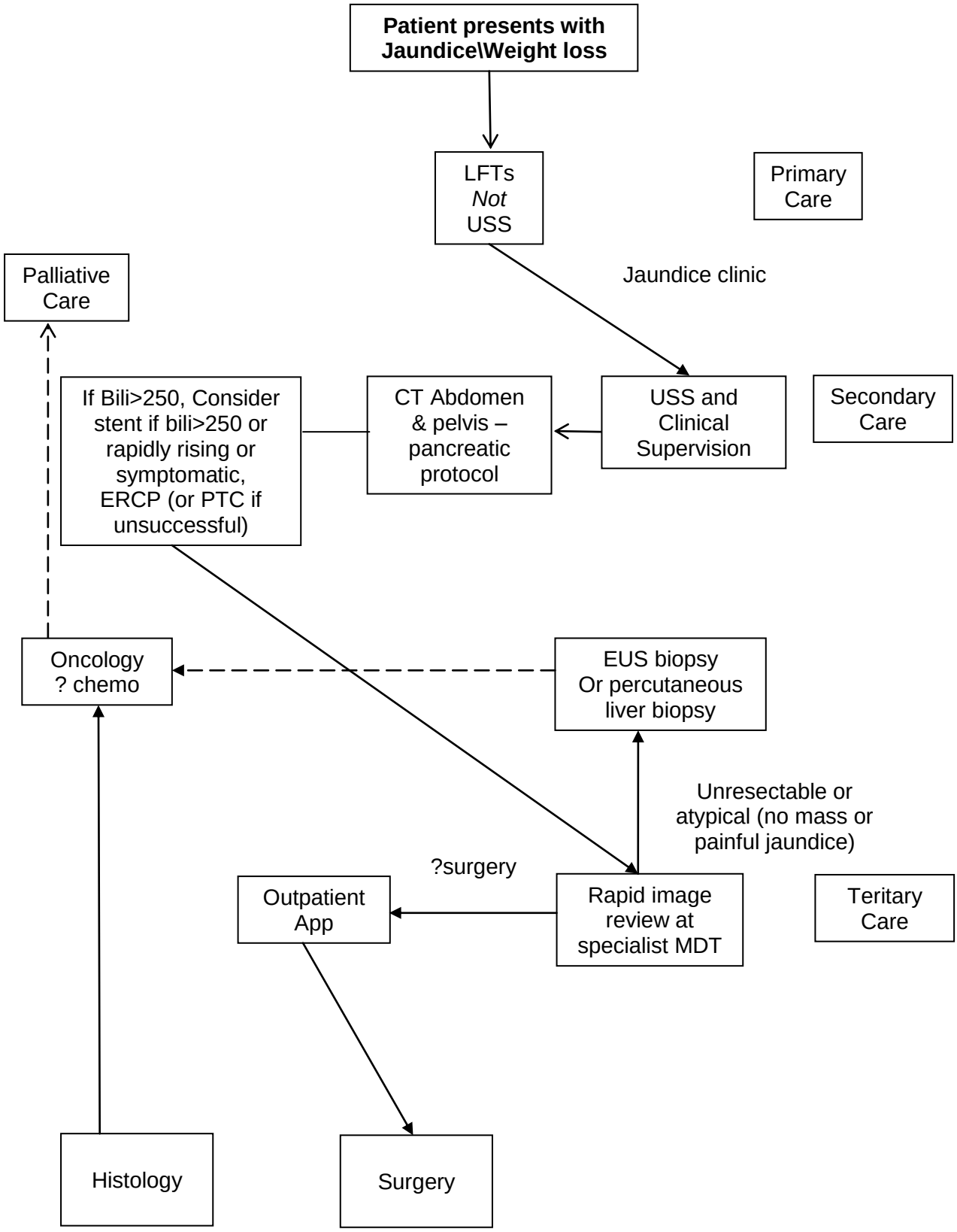
Stenting:

- Please try to refer patient/scans before this is needed
- Better deferred until after assessment CTs by local and tertiary MDTs
- Restrict to cases where bilirubin is > 250 mmols/l or rapidly rising or symptomatic (eg with difficult pruritus)
- If patients are investigated and referred quickly resection may be appropriate without stenting.
- If stenting is necessary a metal stent is preferred even if considering resection

Biopsy

- Biopsy at EUS should be considered if atypical presentation (pain + jaundice) and/or atypical imaging (eg no mass)
- If patient undergoes ERCP, brushings should be performed routinely
  If resection is not planned, biopsy or cytology is recommended for all patients to plan chemotherapy
- Such biopsies may be obtained by EUS or percutaneously if liver metastases

PANCREATIC PATIENT PATHWAY



NON JAUNDICED PATIENTS

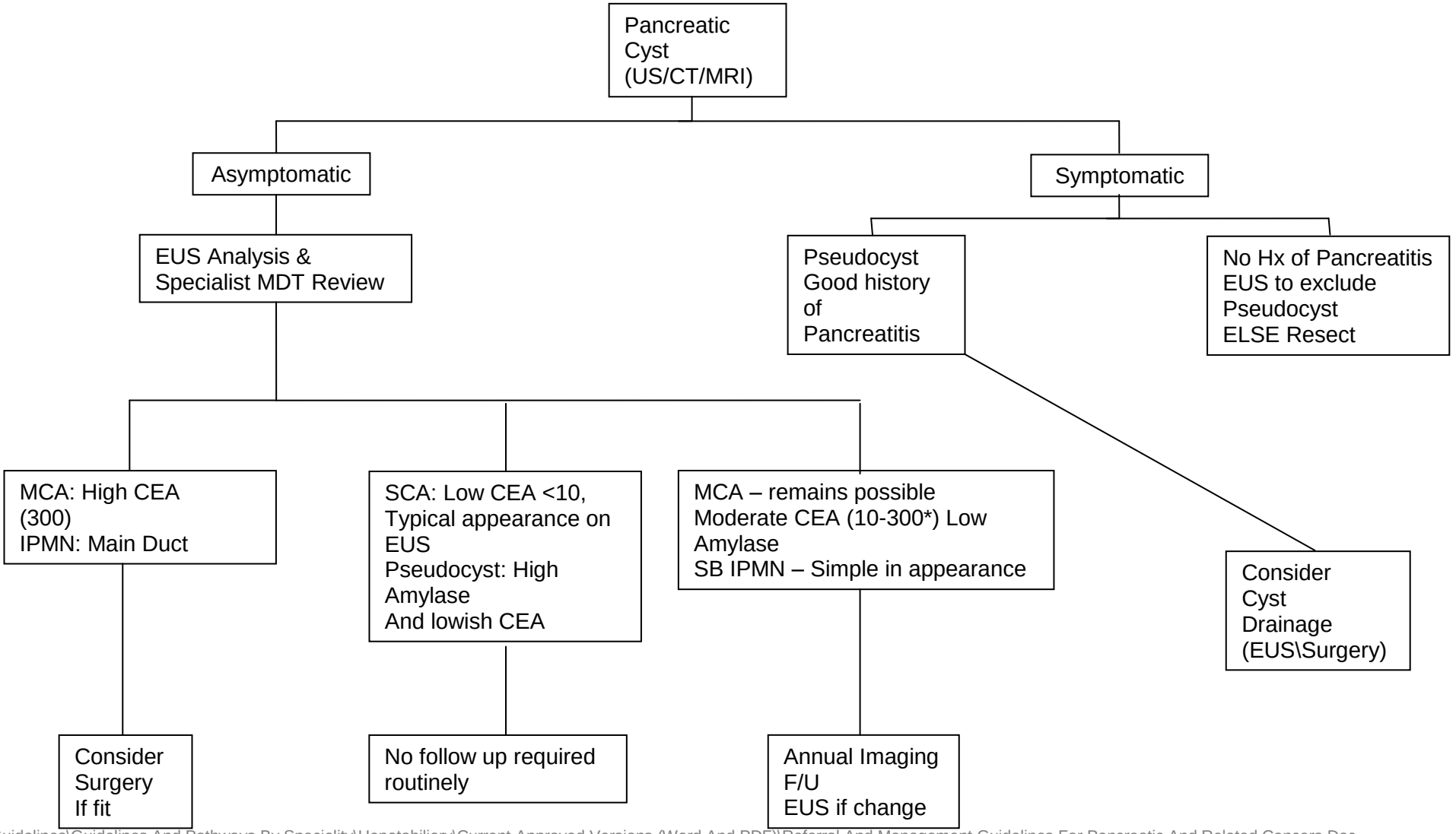
This group of patients includes cancer of the body of the pancreas or duodenum, neuroendocrine and cystic neoplasms of the pancreas.

Pancreatic body cancers. These may present relatively late and not be resectable. Referral of images is recommended. Biopsy – EUS if likely resectable to reduce seeding, otherwise percutaneous biopsy could also be considered in order to distinguish from endocrine tumours. Percutaneous biopsies are however rarely required with the availability of EUS and this should be discussed at MDT first.
Cancer of the duodenum. This often presents with vomiting from obsruction and surgical resection may be possible. CT scans will usually clarify whether this is likely and whether resection can be more local to the duodenum or require a full pancreatico-duodenectomy. If this is not possible, palliation may be obtained with a by-pass using either laparoscopic or open surgery (duodenal stenting may be less invasive if appropriate).

Endocrine tumours. These are not often hormonally active but are slow growing, so that it is important to distinguish them from pancreatic cancer. Patients can benefit greatly from surgery, even palliative, and different chemotherapy regimens. Biopsy is requried by EUS or percutaneously.

Cystic neoplasms of the pancreas. These may be malignant or premalignant and need to be distinguished from pseudocysts. This may require further imaging and fluid sampling by EUS.

Pancreatic Cysts: Pathway



***CEA values can vary considerable according to the type of assay used**

REFERRAL INFORMATION

It is important to include information which will facilitate the tertiary centre MDT discussion, and enable the most efficient outcome for the patient. This should include the following, and a sample form is appended:

- Patient details including phone number
- Brief history Investigations performed, including bilirubin level
- Patient's knowledge of condition
- What is the question for the MDT
- Is an outpatient appointment also requested

MANAGEMENT

Surgery

Only 15-20% of patients with pancreatic cancer achieve successful resection of the tumour. This will require a pancreatico-duodenectomy operation for most, or distal pancreatectomy for others. This will be performed in the tertiary centre. Preoperative biopsy is not normally appropriate except in atypical cases.
Pathology Specimens should be reported in line with the Royal College of Pathologists Minimum dataset for reporting cancers (www.rcpath.org.uk). Staging will be by the TNM system.

Adjuvant chemotherapy

This is recommended for all patients who undergo a normal postoperative recovery. Once final histological staging has been presented to the tertiary centre MDT, a plan for this is agreed which should include entry to an appropriate clinical trial if possible. If possible, this may be administered at the secondary centre.

Follow up

It is important that all resected patients are followed up, to offer best care and to acquire survival data. The tertiary centre will see patients in the early postoperative period and at 6 months, at least. After this, follow up to 5 years may be in the secondary care hospital for patient convenience.

Best Supportive care The majority of patients fall into this category. The diagnosis may be made in secondary care centre in most cases and ratified by the tertiary centre. It is important that the patient's journey is not needlessly confused by unnecessary consultations and referrals, if the diagnosis can be made confidently in one centre. Unless the patient's condition is terminal, biopsy or cytology should be obtained for information, to help plan chemotherapy and to exclude an endocrine tumour. This may be achieved by:

- Brushings at ERCP or PTC

- EUS biopsy
- Percutaneous liver biopsy of metastasis

Palliative chemotherapy

This should be offered to patients, dependant upon co-morbidities who are not terminal. Gemcitabine is NICE recommended and offers a reasonable chance of response to many patients when given alone or in trial combinations. This may be delivered in the secondary care centre.

Duodenal obstruction

This occurs in a small proportion of patients with advanced pancreatic cancer. It presents as persistent vomiting and may be missed. If the patient is not terminal, palliation may be achieved by:

- Endoscopic stenting
- Laparoscopic or open surgical by-pass

Patient Support

It is essential that all patients are engaged at diagnosis with their local palliative care teams. A good number of the patients falling in to this group will never be admitted to hospital and treated mainly in the out patient setting. With the patient's agreement Macmillan and District Nurse referrals shoud be completed to give these patients access to support with in the Primary Care and voluntary sector.

Reference

BSG Guidelines for the Management of patients with Pancreatic cancer, peri-ampullary and ampullary carcinomas GUT 2005; 54;1-16

Sample referral proforma

REFERRAL DETAILS FOR HPB MDT

Referring Hospital

Consultant

Contact Details: Phone / Fax / E-mail

Patient Name DOB

Hosp Number

Date

Brief Clinical History

What is the patient's knowledge?

What investigations have been done so far?

What is your question for the MDT:

Do you wish us to see this patient an appointment if deemed appropriate?

If a letter has been sent, by whom to whom? Yes/No If possible, please fax to the number below

Please use this form to help us deal more efficiently and speedily with your patient

Contact Details for Specialist MDT Referrals

University Hospital North Staffordshire

Case referrals are co-ordinated from MDT co-ordinator to MDT Coordinator

Please fax request to MDT co-ordinator Euan Kirkham on 01782 554888

Or email to: -MDT co-ordinator Euan.Kirkham@nhs.net
With a copy to the Clinical Nurse Specialist emma.rylands@nhs.net

MDT Co-ordinator: -Phone 01782 555365
Nurse Specialists:
01782 553101 or page via switch emma.rylands@nhs.net lyn.walker@nhs.net

University Hospital Birmingham

MDT Coordinator:
Samantha.Gladwin@uhb.nhs.uk

Clinical Nurse Specialists: Catherine.Markham@uhb.nhs.uk 0121 371 4652
Helen.Hewitt@uhb.nhs.uk

University Hospitals Coventry and Warwickshire

Please FAX request to Matt Russell HPB MDT Facilitator on 02476966078

Or email to us at hpb@uhcw.nhs.uk

If you have any difficulty please ring the HPB CNS on 02476965618 or Matt on 02478966082

MDT Coordinator: Matt Russell on 02476 966082 Nurse Specialists Liz Hands or Jenny Merry by bleep 02476 964000 Or email to hpb@uhcw.nhs.uk