Surgery feasible in 20pc of cases

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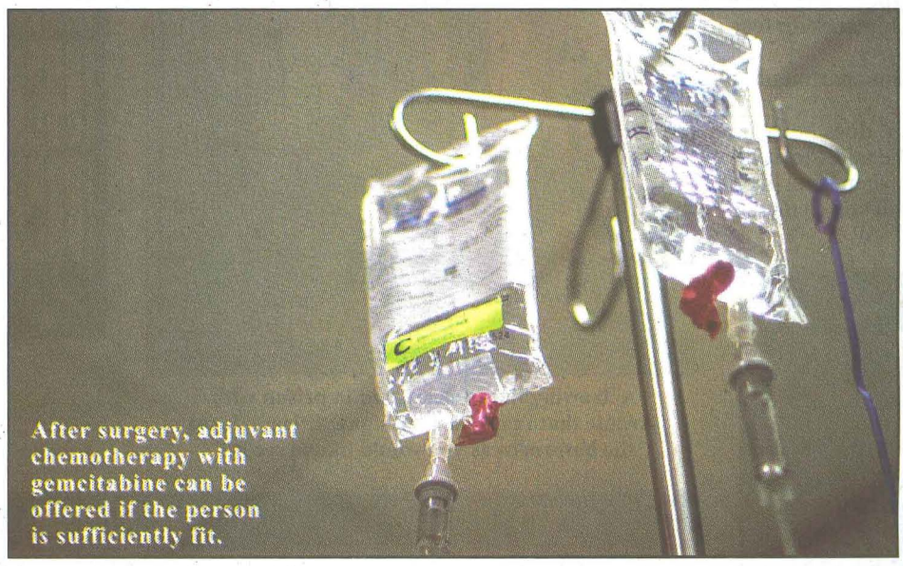

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THE final assessment after diagnosis in exocrine or pancreatic cancer (PC) is whether surgical removal of the tumour is possible as this is the only cure for this cancer. Whether or not surgical resection can be offered depends on how much the cancer has spread. Chemotherapy and, to lesser extent, radiotherapy are likely to be offered to most people, whether or not surgery is possible. Specialist advice that the management of PC should be in the hands of a multidisciplinary team and best conducted in larger centers.

Surgery: Surgery with intention of a cure is only possible in around one-fifth (20 per cent) of new cases. Although CT scans help, in practice it can be difficult to determine whether the tumour can be fully removed ("resectability") and it may become apparent during surgery that it is when the operation appears to have been successful, cancerous cells are often found around the edges ("margins") of the removed tissue. When a pathologist examines them microscopically, indicating the cancer has not been entirely removed.

Although curative surgery no longer entails very high death rates that occurred until 1980s, a high proportion of people (about 30-45 per cent) still have to be treated for a post-operative sickness that is not caused by the cancer itself. The most common complications of surgery is difficulty in emptying the stomach.

Chemotherapy: After surgery, adjuvant chemotherapy with gemcitabine or 5-FU can be offered if the person is sufficiently fit, after a recovery period of one to two months.

The FOLFIRINOX chemotherapy regimen using four drugs was found more effective than gemcitabine, but with substantial side effects and, thus, only suitable for people with good performance status.

However, the changes of the last few years have only increased survival times by a few months. Clinical trials are often conducted for novel adjuvant therapy.

Radiotherapy: The role of radiotherapy as an auxiliary (adjuvant) treatment after potentially curative surgery has been controversial since the 1980s. The European Society for Medical Oncology recommends that adjuvant radiotherapy should only be used for people enrolled in clinical trials. Radiotherapy may form part of treatment to attempt to shrink a tumour to a respectable state, but its use on unrespectable tumours remains controversial as there are conflicting results from clinical trials.

The preliminary results of one trial, presented in 2013, "markedly reduced enthusiasm" for its use on locally advanced tumour.

PanNETs: Treatment of PAnNETs including the less common malignant types, may include a number of approaches that include:

Small tumours of less than 1 cm that are identified accidentally for example on a CT scan performed for other purposes, may be followed watchful waiting. Tumours within the pancreas only (localised tumours) or with limited metastasis, for example to the liver may be removed by surgery. The type of surgery depends on the tumour location, and the degrees of spread to lymph nodes.

b) Localised tumours: The surgical procedure may be much less extensive than the types of surgery used to treat pancreatic adenocarcinoma but, otherwise, surgical procedures are similar to those for exocrine tumours. Use of liver transplantation may be considered in certain cases of liver metastatis.

c) Functioning tumours: The somatostatin analogue class of medications, such as ocreotide, can reduce the excessive production of hormones. Lanreotide can slow tumour growth. Standard cytotoxic chemotherapy is generally not very effective for PanNets, but may be used when other drug treatments fail to prevent the disease from progressing.

Survival: Pancreatic adenocarcinoma and other less common exocrine cancers have a very poor prognosis, as they are diagnosed at a late stage when cancer is already locally advanced or has spread to other parts of the body. Outcomes are better much better for PanNETs: many are benign and completely without clinical symptoms, and even those cases not treatable with surgery have an average five-year survival rate of 16 per cent, although outlooks vary considerably according to the type. In less than 20 per cent of cases of pancreatic adenocarcinoma with a diagnosis of a localised and small cancerous growth (less than 2 cm in Stage 1) about 20 per cent of Americans survive to five years.

Palliative care

Palliative care focuses not on treating the underlying cancer, but on treating symptoms such as pain or nausea, and assist in decision-making, including when or if hospice care will be beneficial. Pain can be managed with medications such as opioids or through procedural intervention, by a nerve block on the celiac plexus.

Both surgery and advanced inoperable tumours often lead to digestive system disorders from a lack of the exocrine products of the pancreas (exocrine insufficiency).

These can be treated by taking pancreatin which contains manufactured enzymes and is best taken with food. Difficulty emptying the stomach (delayed gastric emptying) is common and can be a serious problem, involving hospitalisation, nasogastric aspiration and medication (proton pump inhibitors or H2 antagonistic).

Prevention

Apart from not smoking. The American Cancer Society recommends keeping a healthy weight and increasing consumption of fruits and vegetables, and whole grains, while decreasing consumption of red or processed meat. Although there is no consistent evidence this will prevent or reduce PC specifically.

A 2014 review of research concluded that there was evidence that consumption of citrus fruits and curcumin reduced risk of PC, while there was possibility a beneficial effect from whole grains, foliate selenium, and non-fried fish.

General population screening not considered effective, nevertheless, regular screening with endoscopic ultrasound and MRI/CT imaging is recommended for those at high risk from inherited genetics.

Conclusions

PC has high mortality worldwide. Early detection, surgery, radiotherapy or chemo therapy have better outcome. Prevention includes, not smoking, high fruit and vegetable intake, and decreasing consumption of red and processed meat.

Summary

Pancreatic adenocarcinoma has high prevalence and mortality. Disease is more common in individuals over 70 and rarely occurs before the age of 40. Contributory factors for PC include advance age, male gender, more common in African American than African in their native Africa, smoking, obesity, family history, chronic pancreatitis, diabetes mellitus, red and processed meat, and strong evidence with heavy drinking. Pancreatic adenocarcinoma (exocrine type cancer) are more common than neuroendocrine type cancer. In the early stages there are no symptoms of the disease.

Pain in the upper stomach, jaundice, unexplained weight loss, tumour may compress neighbouring organs and 50 per cent of patients with pancreatic adenocarcinoma also have diabetes. Diagnosis by medical imaging. Treatment with surgery, radiotherapy, chemotherapy and palliative care.

Prevention, bot smoking, limiting the intake of red and processed meat, healthy weight and consumption of fruits and vegetables. Early detection and treatment have better outcome.

Disclaimer: Information provided in this paper is for general information of readers and not medical advice; individuals with clinical symptoms of PC, mentioned above should seek prompt medical advice from healthcare providers.

About the authors

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