THE CANADIAN ASSOCIATION OF GENERAL PRACTITIONERS IN ONCOLOGY
CAGPO
L'ASSOCIATION CANADIENNE DES MÉDECINS OMNIPRATICIENS EN ONCOLOGIE
ACMOO

PANCREATIC CANCER CASE

Case #1

Pancreatic Cancer Case

A 57-year-old black male presents to his family doctor with a 2-month history of epigastric discomfort. He denies nausea or vomiting. There has been no change in his bowel or bladder function. He is anorexic and has lost 5 kilograms in weight.

His family history is significant for colon cancer in his father at age 62. The patient is otherwise healthy. He is a previous smoker of 20 pack years, and a social alcohol consumer of 3-5 drinks/week.

On physical examination there is no lymphadenopathy palpable in the neck, axilla, or inguinal regions. Respiratory and cardiovascular examinations are normal. Abdominal examination does not reveal any abnormality.

1. How would you investigate this patient?
2. What is included in your differential diagnosis?

His lab work including CBC, electrolytes and liver function tests are normal including lipase and amylase. CXR is clear. Abdominal ultrasound questions a mass in the tail of the pancreas. There is no obvious lymphadenopathy. He subsequently undergoes a CT scan of his chest, abdomen, and pelvis. CT chest is clear. CT abdomen and pelvis confirms a 3 cm mass in the tail of the pancreas. No obvious nodal enlargement is seen. There is no evidence of vascular invasion of major vessels or distant metastases.

3. Based on the CT scan, what stage of disease does this patient have?
4. Is there a role for tissue diagnosis pre-operatively in a patient with a suspected pancreatic primary that appears resectable on CT imaging?
5. What is the role of surgery for this type of presentation? What would be the recommended surgical procedure? What is the expected mortality associated with this procedure?
6. From the surgical perspective, who should perform this patient's operation, in order to achieve the best surgical outcome with the lowest operative complication rate and mortality?
7. What is the role of tumour markers such as CA19-9?

He subsequently undergoes a pancreaticoduodenectomy. He has an uncomplicated post-operative course. Pathology reveals a 2.5cm duct cell carcinoma. Resection margins are negative and none of the nodes have metastatic disease. His pre-operative CA 19-9 was 75. Post-operatively, CA 19-9 normalizes.

8. Would this patient benefit from adjuvant systemic therapy? If so, what would you offer him and how would it be administered? What options are available for adjuvant chemotherapy and how would you choose between them?
9. What are the expected toxicities?

10. What is the expected benefit regarding improvements in survival with adjuvant systemic therapy?
11. What is the role of radiation in the setting of complete surgical resection of a pancreatic primary? Would it change if there was a positive surgical margin?
12. How would treatment recommendations be altered if this were a case of locally advanced (unresectable) disease? Is there a role for neoadjuvant systemic therapy?
13. What is the recommended follow up after adjuvant chemotherapy is complete? Is there a role for follow up imaging? Why or why not?

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