Pancreatic Cancer

An overview for GPs

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Let’s drive earlier diagnosis
The Pancreas

87% of UK population cannot identify where in their body the pancreas lies*

*Pancreatic Cancer Action Ipsos Mori poll 2013.
Most patients diagnosed too late:

Only 10% dx in time for surgery.

50% patients never heard of pancreatic cancer.

83% of UK population doesn’t know where pancreas situated.

Average life expectancy 4-6 months

5-year survival only 4% (no change in 40 years)

Pancreatic Cancer Action Patient Survey 2015:

Before referral for tests, 40% patients visited their GP 4 times or more.

1 in 10 had 10+ appointments

61% of patients said their GP initially dismissed symptoms
If diagnosed in time

Survival increases ten-fold...

Surgical resection “Whipple’s procedure” or distal pancreatectomy & splenectomy followed by adjuvant chemotherapy can increase survival by up to ten-fold
In 2013, 9,389 people were newly diagnosed with pancreatic cancer in the UK, an increase of 6% on 2012.

The number of people diagnosed with pancreatic cancer in the UK has been steadily rising.

In 2013, the number of deaths due to pancreatic cancer in the UK was 8,524.

Nearly 24 people a day and nearly one person an hour will die from pancreatic cancer in the UK.
Pancreatic cancer has the lowest survival of all common cancers.
There have been huge improvements in survival for most cancers...

Sadly the same isn’t true for pancreatic cancer
UK pancreatic cancer one-year survival rates are the lowest in the Europe
Incidence in the UK is predicted to rise
Most patients diagnosed too late:

61% of patients said their GP initially dismissed symptoms

BUT...

Over half of patients said they too dismissed their symptoms

From visiting their GP with symptoms, nearly one third had to wait four months or more before a referral to a specialist.

14% had to wait 12 months or more.

18% opted to get a private referral (usually due to the length of wait for imaging tests).
Possible reasons for delays in diagnosis

- Complex presentations especially in the presence of co-morbidities
- Patient delay such as prolonged time to re-visit or simply choosing not to visit their GP
- System delays within primary and secondary care
- Clinical delay
- Health inequalities
### Clinical Presentation: Classic symptoms

The Map of Medicine lists the following as the most common symptoms:

<table>
<thead>
<tr>
<th>MOST COMMON</th>
<th>OTHER COMMON</th>
</tr>
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<tbody>
<tr>
<td>Epigastric Pain:</td>
<td>• Nausea</td>
</tr>
<tr>
<td>occurs in approximately 70% of cases</td>
<td>• Anorexia</td>
</tr>
<tr>
<td>Jaundice:</td>
<td>• Malaise</td>
</tr>
<tr>
<td>occurs in approximately 50% Of cases</td>
<td>• Vomiting</td>
</tr>
<tr>
<td>Unexplained weight loss</td>
<td></td>
</tr>
<tr>
<td>Occurs in 10-30% of cases</td>
<td></td>
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</table>

These symptoms however are often signs of late-stage/inoperable disease.
Symptoms

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A-Typical symptoms

New onset type 2 diabetes mellitus:
New-onset type 2 diabetes in an underweight or normal weight patient, not associated with weight gain

Resistant dyspepsia/persistent epigastric pain:
Patients may also describe their abdominal pain radiating to the back and/or back pain that is relieved on leaning forward.

IBS like symptoms in those >45 years:
IBS is very rare as a new onset symptom at this age and should ring alarm bells so it is essential to think of and exclude pancreatic carcinoma as a cause for bloatedness and flatulence.

Altered bowel movements:
A patient may notice increased bowel movement frequency and pale, offensive smelling stools that don’t flush away easily.

Venous Thromboembolism:
A Deep Vein Thrombosis (DVT) may be a manifestation of an underlying malignancy. If a patient presents with no obvious risk factors it is worth considering an abdominal malignancy such as pancreatic cancer.
The “Silent” killer? Frequency of reported symptoms - recent studies (Schmidt-Hansen et al, 2015)

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
<td>42.4%</td>
<td>41.2%</td>
<td>39.8%</td>
<td>39.8%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Jaundice</td>
<td>30.5%</td>
<td>32.3%</td>
<td>Not reported</td>
<td>Not reported</td>
<td>30.8%</td>
</tr>
<tr>
<td>New-onset diabetes</td>
<td>22.1%</td>
<td>23.6%</td>
<td>Not reported</td>
<td>Not reported</td>
<td>13.6%</td>
</tr>
<tr>
<td>Change in bowel habit</td>
<td>22.3%</td>
<td>23.5%</td>
<td>Not reported</td>
<td>3.3%</td>
<td>27.4%</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>2%</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>16.2%</td>
<td>16.7%</td>
<td>Not reported</td>
<td>Not reported</td>
<td>16.6%</td>
</tr>
<tr>
<td>Weight loss</td>
<td>9.7%</td>
<td>10.7%</td>
<td>7.8%</td>
<td>7.8%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Malaise</td>
<td>5.1%</td>
<td>5.7%</td>
<td>Not reported</td>
<td>Not reported</td>
<td>10.5%</td>
</tr>
<tr>
<td>Bloating</td>
<td>Not reported</td>
<td>Not reported</td>
<td>1.2%</td>
<td>2.4%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Non-cardiac chest pain</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>12%</td>
</tr>
<tr>
<td>Shoulder pain</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>4.9%</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>Not reported</td>
<td>Not reported</td>
<td>1.4%</td>
<td>2.7%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Appetite loss</td>
<td>Not reported</td>
<td>Not reported</td>
<td>3.5%</td>
<td>3.5%</td>
<td>Not reported</td>
</tr>
</tbody>
</table>
Positive Predictive Values (PPVs) of symptoms

For patients $\geq 60$ yrs, the PPVs for individual symptoms is very low - with the exception of jaundice.

For symptom pairs, where jaundice is one of the symptoms, PPVs were 8.9 or greater.

For symptom pairs where unintentional weight loss is paired with another symptom, PPVs ranged from 1.5% - 2.7%

Cancer Decision Support Tool

Based on 2 risk calculators:

Qcancer:
- Pts risk factors: age, sex, deprivation, smoking history, alcohol consumption etc
- Plus presenting symptoms
- Calculator = absolute risk of pt having cancer

RAT:
- End product of series of studies in primary care.
- Single symptoms and double symptom PPVs

The CDS Tool
- Pilot in 2013 with 550 GP practices
- Now working to integrate with main GP IT providers

Assists GPs with the cancer diagnosis alongside the relevant guidance and allows conversations with patients about their risk of having cancer
Pancreatic cancer

Refer people using a suspected cancer referral (for an appointment within 2 weeks) for pancreatic cancer if they are age 40 and over and have jaundice [new 2015]

Consider an urgent direct access CT scan (to be performed within 2 weeks), or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss and any of the following:

- diarrhoea
- back pain
- abdominal pain
- nausea
- vomiting
- constipation
- new-onset diabetes. [new 2015]

Direct access to imaging (CT) to become available (Cancer Taskforce recommendation)
Who’s at risk?

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40% of patients are UNDER the age of 69
Pancreatic cancer

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- nausea
- vomiting
- constipation
- new-onset diabetes. [new 2015]

Direct access to imaging (CT) now available – how does the practice feel about this?
Can new-onset diabetes hold the clue to increasing early diagnosis?

Studies show that between 14% and 24% of pancreatic cancer patients present with new onset diabetes.

It has been found that pancreatic cancer induced hyperglycaemia (high blood glucose levels) can occur up to 24 months prior to the diagnosis for pancreatic cancer (Chari et al, 2008)


• Small audit of GP practice on South Coast England of newly diagnosed diabetes patients with BMI < 25 found 9 patients.

• All sent for US tests

• One found to have undiagnosed pancreatic cancer (albeit too late for surgical resection)

Pancreatic Cancer Action to widen the study to include more GP practices
Independent Cancer Taskforce recommendations for early diagnosis

Ambition that:

- By 2020, 95 per cent of patients referred for testing by a GP are definitively diagnosed with cancer, or cancer is ruled out, and that patients get this result within four weeks.

- This requires a significant increase in diagnostic capacity, giving GPs direct access to key investigative tests, and the testing of new models which could reduce the burden and reliance on GPs.

- Currently, patients urgently referred for suspected cancer by their GP need to be seen by a specialist within 14 days of referral, but no guidance exists for when patients can expect to get the results.

The Independent Cancer Taskforce was established by NHS England on behalf of the Care Quality Commission, Health Education England, Monitor, Public Health England, NICE and the Trust Development Authority in January 2015 to develop a five-year strategy for cancer services.
Treatment options

If diagnosed in time:
Surgical resection “Whipple’s procedure” followed by adjuvent chemotherapy using Gemcitabine.
Metastatic pancreatic cancer (80% cases)

Chemotherapy – current standard is gemcitabine + Abraxane
Only approved in Scotland & Wales for NHS use – England not currently available
Others include FOLFIRINOX - combination of fluorouracil (5-FU), leucovorin, irinotecan and oxaliplatin
BUT is highly toxic and can only be administered to patients with excellent performance status.
For localised and borderline resectable patients

Approx. 30% of pancreatic cancer cohort

Increasing use of Neo-adjuvant therapies including:

- Chemotherapy
- Chemoradiotherapy
- Irreversible Electroporation (IRE)
- Proton Beam Therapy (not used in UK)

Many therapies still unproven as part of wider randomised clinical trials

Small numbers of patients have tumours downstaged to operable
LEARN MORE: Pancreatic cancer e-learning modules

For GPs:

www.elearning.rcgp.org.uk/pancreatic

For hospital doctors:

http://learning.bmj.com/learning/module-intro/.html?moduleId=10051332