

ASCO® Guidelines

POTENTIALLY CURABLE PANCREATIC ADENOCARCINOMA: ASCO CLINICAL PRACTICE GUIDELINE UPDATE

Clinical Question	Recommendation	Evidence Rating
<p>After a histopathologic confirmation of pancreatic adenocarcinoma diagnosis, what initial assessment is recommended before initiating any therapy for potentially curable pancreatic cancer?</p>	<p>A multiphase computed tomography (CT) scan of the abdomen and pelvis using a pancreatic protocol or magnetic resonance imaging (MRI) should be performed for all patients with pancreatic cancer to assess the anatomic relationships of the primary tumor and to assess for the presence of intra-abdominal metastases. Endoscopic ultrasonography and/or diagnostic laparoscopy may be used as supplemental studies, and to facilitate acquisition of a biopsy specimen. A chest X-ray may be performed to stage the thorax. Other staging studies should be performed only as dictated by symptom burden. A serum level of CA 19-9 and baseline standard laboratory studies should be assayed.</p>	<p>Type: Evidence based, benefits outweigh harms Evidence quality: High Strength of recommendation: Strong</p>
	<p>The baseline performance status, symptom burden, and comorbidity profile of a person diagnosed with potentially curable pancreatic cancer should be carefully evaluated.</p>	<p>Type: Evidence based, benefits outweigh harms Evidence quality: High Strength of recommendation: Strong</p>
	<p>The goals of care (including a discussion of advance directives), patient preferences, and support systems should be discussed with every person diagnosed with potentially curable pancreatic cancer and his or her caregivers.</p>	<p>Type: Evidence based, benefits outweigh harms; Evidence quality: Intermediate; Strength of recommendation: Strong</p>
	<p>Multidisciplinary collaboration to formulate treatment and care plans and disease management for patients with potentially curable pancreatic cancer should be the standard of care.</p>	<p>Type: Evidence based, benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Strong</p>

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Clinical Question	Recommendation	Evidence Rating
	Every person with pancreatic cancer should be offered information about clinical trials, including therapeutic trials in all lines of treatment, as well as palliative care, biorepository/biomarker, and observational studies.	Type: Informal consensus, benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Strong
Which patients with potentially curable pancreatic cancer should be offered a potentially curative strategy with primary tumor resection?	Primary surgical resection of the primary tumor and regional lymph nodes is recommended for patients with potentially curable pancreatic cancer who meet all of the following criteria: no clinical evidence for metastatic disease, a performance status and comorbidity profile appropriate for a major abdominal operation, no radiographic interface between primary tumor and mesenteric vasculature on high-definition cross-sectional imaging, and a CA 19-9 level (in absence of jaundice) suggestive of potentially curable disease.	Type: Evidence based, benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Strong
Which patients with potentially curable pancreatic cancer should be offered a potentially curative strategy with preoperative therapy, followed by a planned primary tumor resection?	Preoperative therapy is recommended for patients with pancreatic cancer who meet any of the following criteria: radiographic findings suspicious but not diagnostic for extrapancreatic disease, a performance status or comorbidity profile not currently appropriate (but potentially reversible) for a major abdominal operation, a radiographic interface between primary tumor and mesenteric vasculature on cross-sectional imaging that does not meet appropriate criteria for primary resection, or a CA 19-9 level (in absence of jaundice) suggestive of disseminated disease.	Type: Evidence based, benefits outweigh harms; Evidence quality: Low; Strength of recommendation: Strong
	Preoperative therapy should be offered as an alternative treatment strategy for any patient who meets all criteria in Recommendation 2.1.	Type: Evidence based, benefits outweigh harms Evidence quality: Low Strength of recommendation: Strong
	If preoperative therapy is administered, a complete restaging evaluation is recommended after completion of treatment and before final surgical planning.	Type: Informal consensus benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Strong

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<p>What is the appropriate adjuvant regimen for patients with pancreatic cancer who have undergone an R0 or R1 resection of their primary tumor?</p>	<p>Updated Recommendation 4.1. All patients with resected pancreatic adenocarcinoma who did not receive preoperative therapy should be offered 6 months of adjuvant chemotherapy in the absence of medical or surgical contraindications. The modified combination regimen of 5FU, oxaliplatin and irinotecan (mFOLFIRINOX) as used in the latter part of the PRODIGE 24/CCTG PA.6 trial (oxaliplatin 85 mg/m², leucovorin 400 mg/m², irinotecan 150 mg/m² D1, and 5-FU 2.4 g/m² over 46 h every 14 days for 12 cycles) is preferred in the absence of concerns for toxicity or tolerance; alternatively, doublet therapy with gemcitabine and capecitabine or monotherapy with gemcitabine alone or fluorouracil plus folinic acid alone can be offered.</p>	<p>Type: Evidence based, benefits outweigh harms Evidence quality: High Strength of recommendation: Strong</p>
	<p>Adjuvant chemoradiation may be offered to patients who did not receive preoperative therapy and present post-resection with microscopically positive margins (R1) and/or node-positive disease after completion of 4 to 6 months of systemic adjuvant chemotherapy as outlined in recommendation 4.1. There is clinical equipoise regarding the benefit of adjuvant radiation therapy in this setting pending results of an ongoing international RCT.</p>	<p>Type: Informal consensus, benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Moderate</p>
	<p>For patients with pancreatic cancer who received preoperative therapy, there are no RCT data to guide the administration of postoperative therapy. The Panel recommends that a total of 6 months of adjuvant therapy (including preoperative regimen) be offered based on extrapolation from adjuvant therapy trials.</p>	<p>Type: Informal consensus, benefits outweigh harms Evidence quality: Low Strength of recommendation: Strong</p>
<p>When should palliative care services be initiated for people with pancreatic cancer that is potentially curable by surgery?</p>	<p>People with potentially curable pancreatic cancer should have a full assessment of symptom burden, psychological status, and social supports as early as possible, preferably at the first visit. In some cases, this may indicate a need for a formal palliative care consult and services.</p>	<p>Type: Informal consensus, benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Strong</p>

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	<p>People who have undergone pancreatectomy for potentially curable pancreatic cancer should receive ongoing supportive care for symptom burden that may result from the surgery and (preoperative and/or adjuvant) chemotherapy.</p>	<p>Type: Informal consensus, benefits outweigh harms Evidence quality: Intermediate Strength of recommendation: Strong</p>
<p>What is the recommended frequency of follow up care/surveillance for people with potentially curable pancreatic cancer after the administration of potentially curative multimodality therapy that includes resection?</p>	<p>In the absence of RCT evidence, the Panel recommends that people who have completed treatment for potentially curable pancreatic cancer and have no evidence of disease be monitored for recovery of treatment-related toxicities and recurrence. Visits may be offered at 3- to 6- month intervals; the role of serial cross-sectional imaging, the extent to which surveillance intervals should be prolonged over time, and the duration of recommended surveillance are all undefined.</p>	<p>Type: Informal consensus, benefits outweigh harms Evidence quality: Low Strength of recommendation: Moderate</p>