

# Pancreas Cancer: A Plea for Multidisciplinary Care

Thomas S. Helling\*

Professor of Surgery, University of Mississippi Medical Center, USA

The American Cancer Society reported the trends in five-year survival for pancreas cancer (predominately pancreatic ductal adenocarcinoma) in 2010. For the cohorts of patients 1975-1977, 1984-1986, and 1999-2005 the five-year survival rates are a dismal three percent, three percent, and six percent respectively. This is in stark contrast to overall cancer survivals from all sites for the same time intervals of 50 percent, 54 percent, and 68 percent [1]. This is at a time when the incidence of pancreatic cancer across the United States has not decreased and, in fact, may have increased [2]. The traditional curative treatment for pancreatic cancer has been resectional surgery. In many patients this has necessitated a radical pancreaticoduodenectomy, or the Kausch – Whipple procedure, with its attendant morbidity and mortality. Still, even with radical surgery the extended survival has not far exceeded 20 percent. Yet treatment of pancreas cancer in many minds remains principally a surgical event.

However, there have been minute advances in the management of this disease. Reduction in mortality and morbidity of the Kausch – Whipple procedure has been substantial, with many centers now reporting less than five percent mortality. This improvement has been due to several factors, including better patient selection, better patient preparation, refined operative techniques, better anesthesia management, and improved postoperative care. Yet, undeniably, the reported reduction in perioperative risk has occurred primarily from centers with high volumes of such patients, as well as in hospitals with adequate system support, such as institution of Leapfrog initiatives, achievement of HealthGrades 5-star rating, general surgery residency programs, gastroenterology fellowships, and interventional radiology services [3]. Introduction of adjuvant and then neoadjuvant chemotherapy and radiation therapy has produced some advantage in survival, at present, merely in terms of months, but the theoretic advantages of neoadjuvant/adjuvant treatment simply awaits the discoveries of better chemotherapeutic, targeted, and immunomodulatory agents. This will best be realized through the design and implementation of appropriate clinical trials. Importantly, though, neoadjuvant treatment has afforded an opportunity to downstage pancreatic cancer and affords at least some of these patients with borderline resectable lesions the opportunity for curative surgery [4].

Improvement in identification of potentially curable patients, selection of patients for neoadjuvant treatment and radical surgery, management of patients perioperatively, and accessibility to clinical trials requires a concerted effort of different specialties, namely, gastroenterology, medical oncology, surgery, radiation oncology, and interventional radiology. This is not necessarily a function of volume but rather that of the Donebedian quality elements of structure, process, and outcome analysis [5]. Cancer care deserves trained specialists and facility support, process measures to guide patient throughput and defined quality care, access to well-designed clinical

trials, and performance improvement initiatives based on careful outcomes analysis. It is time to consider pancreas cancer a disease deserving of multimodality treatment rather than the lone surgical *tour-de-force* of decades past. Curative operations should be performed only in the setting of proper preoperative evaluation, preparation, and treatment planning, ideally involving gastroenterologists, radiologists, radiation oncologists, and medical oncologists, access to clinical trials, comprehensive intraoperative and postoperative management, and careful oncologic follow-up. Perhaps what is most alarming is the sizeable number of patients (perhaps over one-half) with potentially curable pancreas cancer (Stage I disease) who may not even be considered for surgical treatment [6] reflecting either lack of access to multidisciplinary care or failure to properly evaluate and prepare these patients for multimodality treatment, which includes surgery.

This is a plea for multidisciplinary care, not a plea for high volume care. It is perfectly reasonable to assume that appropriate structure, process, and outcome measures will afford patients the quality of care found at so-called centers of excellence. Margination of pancreas cancer victims to the surgery or no surgery paradigm is an injustice, and, as new treatment algorithms become available, it will be increasingly important to avail these patients of the specialists trained to implement quality care. My plea is particularly addressed to surgeons who must recognize that the effective treatment of cancer to prolong quantity and quality of life is more than a challenging operation and is no longer an isolated event but rather a team effort. It is unlikely that surgery for pancreatic carcinoma will ever be unnecessary, but surgery will be increasingly only one element, albeit an important element, in the treatment of this disease.

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\*Corresponding author: Thomas S. Helling, Professor of Surgery, Division of General Surgery, Surgery Program Director, University of Mississippi Medical Center, 2500 North State Street, Jackson, E-mail: [thelling@umc.edu](mailto:thelling@umc.edu)

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