Virginia Mason Pancreatic Head Mass interdisciplinary pathway

Pancreatic Head Mass

Workup done @ VM or placed into VM electronic record *(see Key)*

Labs: **CBC,CMR,CA19-9,CEA, PT,PTT**[∞]
RAD: **CT Panc protocol/ MR pancreas**[α]
Staging: **CXR** or **Chest CT** or **CT-PET**[β]
Database: **GI Tumor Board submission & Entry into cancer database**

Evidence of Metastatic disease?

YES → **Medical Oncology consult**
Tissue bx (2° recommended) EUS *or* CT/US guided *or* laparoscopy

NO ↓

Cystic Mass or Atypical presentation?

- ☐ **Atypical presentation:**
  -Unclear Dx -? Benign stricture
  -? Autoimmune pancreatitis
- ☐ **Mass W/ Cystic component:**

YES → **Follow Cystic Mass pathway** *OR* GI consult for WU and EUS/ERCP as indicated

NO ↓

Resectability and Higher risk factors	Margin Factors & Patient Factors
☐ **Vascular (arterial) abutment** ☐ **Portal Venous Distortion**	☐ Bulky tumor: **>4.5cm tumor with higher risk of R1 resection**
☐ **Vascular encasement or Tumor thrombus**	☐ Patient factors: **high cardiopulmonary risk**
☐ **CA 19-9 > 2000** *(unobstructed & @ VM)*	☐ **Concomitant Mod-Severe Pancreatitis**

NO to *all* above

For all patients	For patients with biliary obst
☐**Perf. Status ≥ 2**	☐ **TB≥20**
☐ **Needs extensive Cardio-pulm w/u**	☐ **Evidence of symptoms or Cholangitis**
☐ **Alb ≤ 2.5** [μ]	☐ **Unble to sch surgery within ~7days**

NO to *all* above → **HPB surgery consult for resection (no stent, no bx)**

Yes to *any* above → **•GI consult:** Biliary stent
•HPB surgery: optimization and eventual operation

μ) *GI to consider NJ feeding tube*

VM resection arm

Yes to *any* above

- ☐ **Medical Oncology consult for Neoadj therapy**
- ☐ **GI consult: 1) EUS for Staging and Bx** *(if bx neg, repeat EUS) (Bx endoscopically positive nodes if NOT peri-pancreatic)* **2) short metal biliary stent** *(if obst present) (Ideally within 72hrs of consult)*
- ☐ **Surgery consult: Dx Lap w/ washings, Port placement**

Restage after Neoadj tx

Metastatic Disease:
-Continue w/ medical oncology for chemo Vs supportive care

No Metastatic Disease:
-GI tumor board presentation
-Absence of progression, <180° on SMA, & reconstructable PV→proceed to intraop (2 surgeon if needed) assessment of resectability

Remains locally adv:
- Neoadj chemo
-XRT consult

Resection → -Tumor board for recommendations of adjuvant therapy and follow-up.

VM Neoadjuvant arm

KEY

∞= *(These labs need to be done @VM)*

α= *(if outside CT is <4 wks old→VM Rad consult for official read using staging template, if >4wks old→ CT Panc @ VM.* ***Must*** *state* **"use Pancreas staging template"** *in order)*
-Note that if outside CT quality does not allow for use of staging template, then radiology will state that in read and a CT panc @ VM is needed

β=*(if any of these are available from outside hospital & are <6wks old then nothing is needed, otherwise order CXR pa & lat @ VM)*