

Ten Best Readings Relating to Pancreatic Cancer

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Varadhachary GR, Wolff RA, Crane CH, et al. Preoperative gemcitabine and cisplatin followed by gemcitabine-based chemoradiation for resectable adenocarcinoma of the pancreatic head. *J Clin Oncol.* 2008;26(21):3487-3495.

Preoperative Gem-Cis-XRT did not improve survival beyond that achieved with preoperative gemcitabine-based chemoradiation (Gem-XRT) alone. The longer preoperative interval required more durable biliary decompression (metal stents) but was not associated with local tumor progression. The gemcitabine-based chemoradiation platform is a reasonable foundation on which to build future phase II multimodality trials for stage I/II pancreatic cancer incorporating emerging systemic therapies.

Sa Cunha A, Rault A, Beau C, et al. A single-institution prospective study of laparoscopic pancreatic resection. *Arch Surg.* 2008;143(3):289-295; discussion 295.

This series demonstrates that laparoscopic pancreatic resection is not only feasible but also safe. The study suggests that the best indications for a laparoscopic approach are presumably benign pancreatic tumors not requiring pancreaticoenteric reconstruction.

Regine WF, Winter KA, Abrams RA, et al. Fluorouracil vs gemcitabine chemotherapy before and after fluorouracil-based chemoradiation following resection of pancreatic adenocarcinoma: a randomized controlled trial. *JAMA.* 2008;299(9):1019-1026.

The addition of gemcitabine to adjuvant fluorouracil-based chemoradiation was associated with a survival benefit for patients with resected pancreatic cancer, although this improvement was not statistically significant.

Senderowicz AM, Johnson JR, Sridhara R, et al. Erlotinib/gemcitabine for first-line treatment of locally advanced or metastatic adenocarcinoma of the pancreas. *Oncology (Williston Park).* 2007;21(14):1696-1706; discussion 1706-709, 1712, 1715.

The combination demonstrated a statistically significant increase in overall survival accompanied by an increase in toxicity. Physicians and patients now have a new option for the treatment of locally advanced/metastatic adenocarcinoma of the pancreas.

Butturini G, Stocken DD, Wente MN, et al. Influence of resection margins and treatment on survival in patients with pancreatic cancer: meta-analysis of randomized controlled trials. *Arch Surg.* 2008;143(1):75-83; discussion 83.

Adjuvant chemotherapy but not chemoradiotherapy should be the standard of care for patients with either R0 or R1 resections for pancreatic cancer.

Tempero M, Arnoletti JP, Ben-Josef E, et al. Pancreatic adenocarcinoma. Clinical Practice Guidelines in Oncology. *J Natl Compr Canc Netw.* 2007;5(10):998-1033.

The NCCN panel recommends that investigational options be considered in all phases of disease management. Specific palliative measures are recommended for patients with advanced pancreatic adenocarcinoma characterized by biliary or gastric obstruction, severe abdominal pain, or other tumor-associated manifestations of the disease.

Lee CJ, Scheiman J, Anderson MA, et al. Risk of malignancy in resected cystic tumors of the pancreas ≤ 3 cm in size: is it safe to observe asymptomatic patients? A multi-institutional report. *J Gastrointest Surg.* 2008;12(2):234-242. Epub 2007 Nov 27.

Among asymptomatic patients who displayed no discernable radiographic features suggestive of malignancy who underwent resection, the incidence of occult malignancy was 3.3%. This study suggests that a group of patients with small cystic pancreatic neoplasms who have low risk of malignancy can be identified, and selective resection of these lesions may be appropriate.

Del Chiaro M, Zerbi A, Falconi M, et al. Cancer risk among the relatives of patients with pancreatic ductal adenocarcinoma. *Pancreatology.* 2007;7(5-6):459-469. Epub 2007 Oct 1.

The data suggest that genetic susceptibility to pancreatic cancer may be attributable, in addition to BRCA2, to moderate- to low-penetrance gene(s).

Jang JY, Kim SW, Lee SE, et al. Treatment guidelines for branch duct type intraductal papillary mucinous neoplasms of the pancreas: when

can we operate or observe? *Ann Surg Oncol.* 2008;15(1):199-205. Epub 2007 Oct 2.

Many branch duct IPMNs are malignant. Surgical treatment is recommended, except in cases that are strongly suspected to be benign or cases that present a high operative risk. Observation is recommended only in patients with a tumor size of ≤ 2 cm without a mural nodule.

Nakagohri T, Kinoshita T, Konishi M, et al. Surgical outcome of intraductal papillary mucinous neoplasms of the pancreas. *Ann Surg Oncol.* 2007;14(11):3174-3180. Epub 2007 Aug 12.

Patients with intraductal papillary mucinous adenoma, noninvasive carcinoma, and minimally invasive carcinoma showed favorable survival. In contrast, invasive intraductal papillary mucinous carcinoma was associated with poor survival regardless of the margin status. Nodal involvement was the strongest predictor of poor survival.