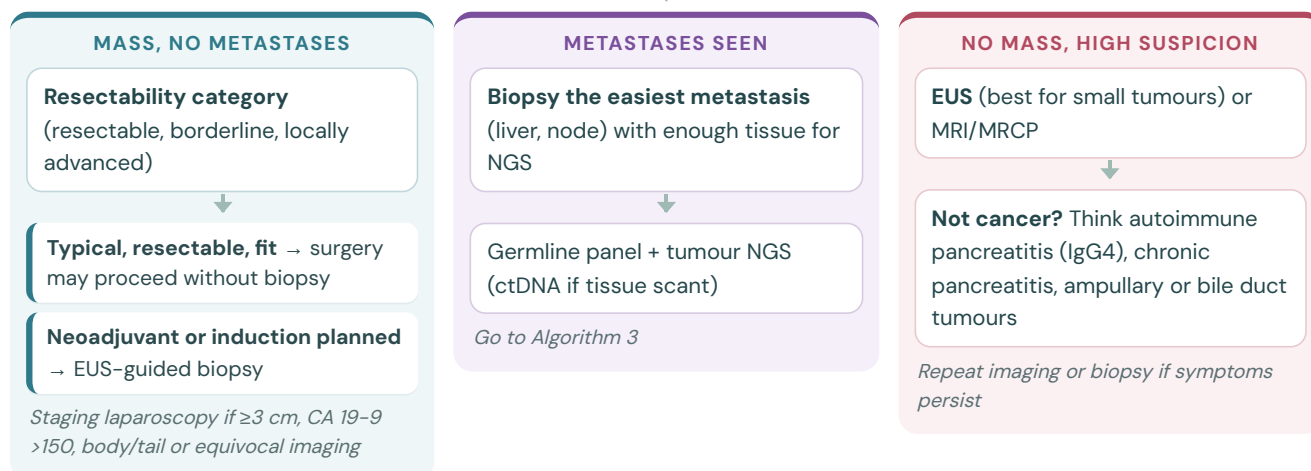


Pancreatic Cancer: Suspected pancreatic cancer: to a staged diagnosis

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist
& Hemato-Oncologist

Jaundice, epigastric or back pain with weight loss, new diabetes with weight loss, unexplained pancreatitis or clot → pancreas-protocol CT abdomen-pelvis + CT chest (before any stent if possible) → pancreatic tumour board



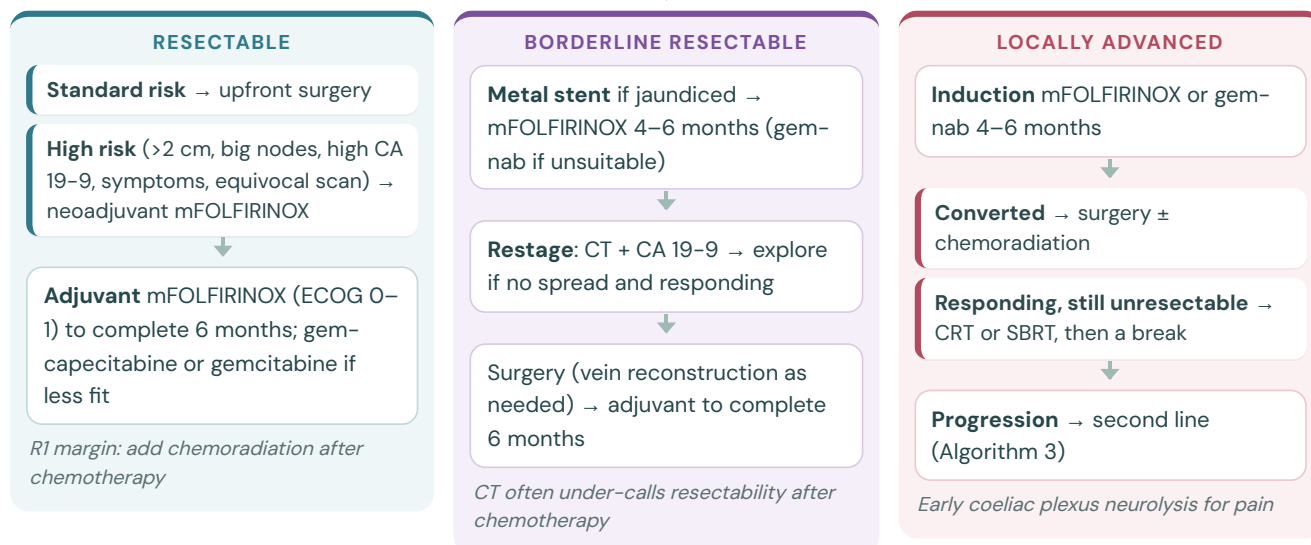
All patients: relieve jaundice only when needed (cholangitis, neoadjuvant plan, delay >2 weeks, very high bilirubin) · CA 19-9 after drainage · germline testing · nutrition and diabetes check · early palliative care where appropriate.

Pancreatic Cancer: Localised disease by resectability

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

No distant metastases → resectability on pancreas-protocol CT → fitness (ECOG, nutrition) → tumour board



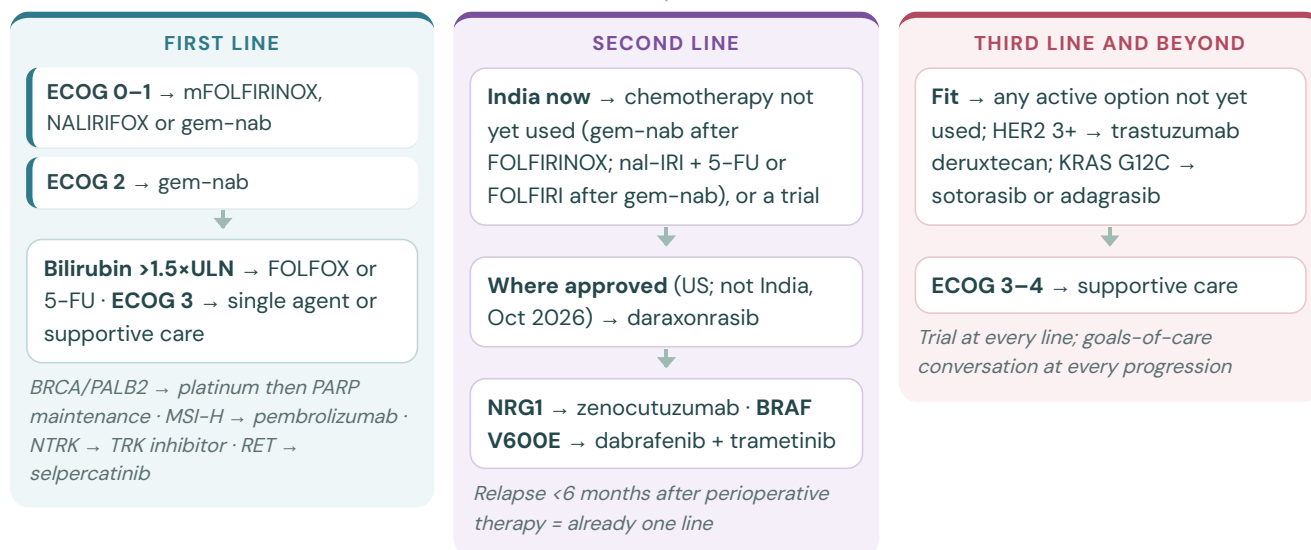
All patients: germline testing · enzymes and diabetes plan · high-volume surgical centre · follow-up CT + CA 19-9 every 3-6 months for 2 years after surgery.

Pancreatic Cancer: Metastatic disease: systemic therapy by line

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Metastatic or recurrent → germline + tumour NGS sent (do not wait to start) → ECOG, bilirubin, comorbidity, goals of care → early palliative care



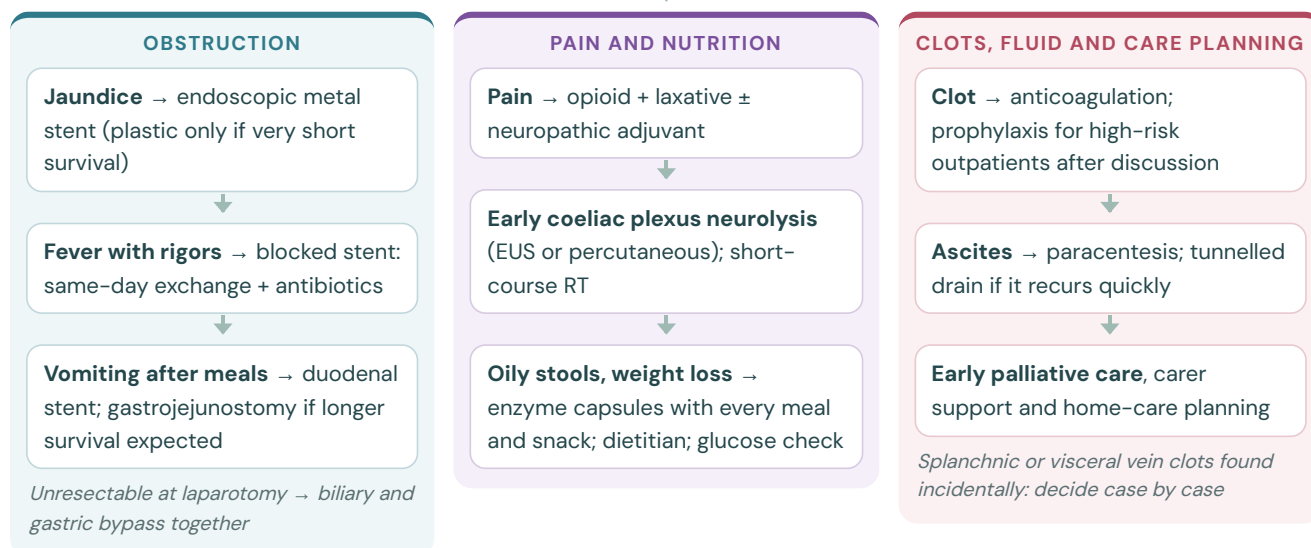
All patients: CT every 2–3 months and CA 19–9 · enzymes · clot awareness · pain plan · nutrition · maintenance after 4 months of control · cost and access plan.

Pancreatic Cancer: Supportive care in advanced disease

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist &
Hemato-Oncologist

At every visit ask about jaundice and fever, vomiting, pain, stools and weight, leg swelling or breathlessness, mood and ascites



All patients: a written plan for fever, jaundice, vomiting and bleeding · phone contact · nutrition support · documented goals of care.

Pancreatic Cancer: Follow-up and survivorship plan

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A simple follow-up rhythm after curative-intent treatment



Every visit: weight, stools (enzyme dose), glucose and HbA1c, pain, mood, smoking and alcohol.

After splenectomy: pneumococcal, meningococcal and Hib vaccines; fever = urgent care. After Whipple: B12, iron, vitamin D.

Family: offer germline results to relatives (cascade testing) and screening when criteria are met.

A simple follow-up rhythm, adapted from NCCN and ESMO; there is no proof that intensive imaging prolongs life, so adapt to the patient and to resources.

Help the treatment work

- Complete 6 months of perioperative chemotherapy
- Enzymes with every meal and snack
- Stop all tobacco; avoid alcohol
- Protein-rich small meals; walk daily
- Germline result shared with the family

Red flags to report

- Fever with chills, or new yellow eyes (stent block)
- Vomiting after meals, early fullness
- Leg swelling, chest pain or sudden breathlessness
- Black stools or vomiting blood
- Diarrhoea more than 4–6 times a day on chemotherapy

Do not forget

- CT + CA 19–9 every 3–6 months for 2 years
- Vaccines after splenectomy; fever plan
- Glucose and HbA1c; B12, iron, vitamin D
- Cascade testing for BRCA/PALB2 families
- Early palliative care in advanced disease

When relapses happen: pattern and options

Most patients relapse after resection, usually within 2 years; liver and peritoneum are commonest, then the surgical bed and lungs.

Liver, peritoneum or many sites

- Systemic therapy by line
- Relapse <6 months after perioperative therapy: treat as second line
- Re-test the tumour (ctDNA or biopsy)

Surgical bed only

- Confirm on PET–CT or EUS biopsy
- Chemotherapy first; then CRT or SBRT
- Re-resection rarely, in expert centres

Lungs only, slow

- Often slower-growing
- Chemotherapy; selected local treatment
- (resection or SBRT) after a period of stability

A rising CA 19–9 often comes before scan changes; confirm with imaging before changing treatment. Early palliative care and a clinical trial should be offered at every relapse.

When relapses happen, the site and the time since the last chemotherapy guide treatment. Based on UpToDate and NCCN; selection for local treatment of oligometastatic disease is individual and evidence comes from observational series.