

The role of endoscopy in the evaluation and management of patients with solid pancreatic neoplasia

Prepared by: ASGE STANDARDS OF PRACTICE COMMITTEE

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This document was reviewed and approved by the Governing Board of the American Society for Gastrointestinal Endoscopy.

This is one of a series of statements discussing the use of GI endoscopy in common clinical situations. The Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy (ASGE) prepared this document that updates a previously issued consensus statement and a technology status evaluation report on this topic.¹ In preparing this guideline, a search of the medical literature was performed by using PubMed between January 1975 and May 2015, with the use of the search terms “pancreatic AND malignancy,” “endoscopy,” “EUS,” and “ERCP.” Additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When limited or no data existed from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts. Recommendations for appropriate use of endoscopy are based on a critical review of the available data and expert consensus at the time the documents are drafted. Further controlled clinical studies may be needed to clarify aspects of recommendations contained in this document. This document may be revised as necessary to account for changes in technology, new data, or other aspects of clinical practice. The recommendations were based on reviewed studies and were graded on the strength of the supporting evidence (Table 1).² The strength of individual recommendations is based both on the aggregate evidence quality and an assessment of the anticipated benefits and harms. Weaker recommendations are indicated by phrases such as “we suggest,” whereas stronger recommendations are typically stated as “we recommend.”

This guideline is intended to be an educational device to provide information that may assist endoscopists in providing care to patients. It is not a rule and should not be construed as establishing a legal standard of care or as encouraging, advocating, requiring, or discouraging any particular treatment. Clinical decisions in any particular case involve a complex analysis of the patient's condition and available courses of action. Therefore, clinical considerations may lead an endoscopist to take a course of action that varies from these recommendations and suggestions.

This document reviews the approach to the evaluation and treatment of the patient with suspected solid pancreatic neoplasia. Table 2 outlines the types of neoplasia discussed in this guideline. A discussion of the role of endoscopy for cystic lesions of the pancreas can be found in another ASGE document.³ Solid lesions of the pancreas can be classified as primary or metastatic, benign or malignant, and arising from the exocrine or endocrine pancreas. The most common and potentially serious solid lesion of the pancreas, pancreatic adenocarcinoma, arises from the exocrine pancreas. An algorithm of the recommended approach to pancreatic adenocarcinoma diagnosis and staging is presented in Figure 1.

PRESENTATION AND CLINICAL EVALUATION

Patients with suspected solid pancreatic neoplasia may present with obstructive jaundice, abdominal pain, anorexia, weight loss, acute pancreatitis, new onset or poorly controlled diabetes, or steatorrhea. The physical examination can include findings such as jaundice, muscle wasting, pertinent skin lesions, palpable adenopathy, hepatomegaly, or masses. Occasionally these lesions will be

TABLE 1. GRADE system for the quality of evidence for guidelines

Quality of evidence	Definition	Symbol
High quality	Further research is very unlikely to change our confidence in the estimate of effect.	⊕⊕⊕⊕
Moderate quality	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.	⊕⊕⊕○
Low quality	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.	⊕⊕○○
Very low quality	Any estimate of effect is very uncertain.	⊕○○○

GRADE, Grading of recommendations assessment, development and evaluation. Adapted from Guyatt et al.²

identified coincidentally on surveillance abdominal imaging tests or during evaluation of unrelated abdominal pain. Elevations in routine or diagnostic liver enzyme testing, especially increased levels of bilirubin and alkaline phosphatase, may lead to a diagnosis of cholestasis due to biliary obstruction localized to the head of the pancreas. Conversely, patients with pancreatic malignancy in the body and tail typically present with more advanced-stage disease and normal liver biochemistry results because of the absence of biliary obstruction. The utility of serum markers such as CA 19-9 in patients with suspected pancreatic neoplasia is controversial. CA19-9 levels are elevated in the peripheral blood of the majority of patients with pancreatic cancer, but this finding does not achieve the performance required for either early detection or diagnosis, because of the potential for both false positive and false negative results.⁴ However, despite its shortcomings, CA 19-9 is the only U.S. Food and Drug Administration approved biomarker recommended for use in the routine management of pancreatic ductal adenocarcinoma. It has been used for prognosis and as a marker of disease burden (ie, recurrence or disease progression).⁵ Suspicion of pancreatic neoplasia should prompt additional investigation with chest and abdominal imaging studies to assist in diagnosis, staging, and therapeutic planning. The staging guidelines included here are from the American Joint Committee on Cancer 7th edition TNM staging system (Table 3).⁶

ADENOCARCINOMA OF THE PANCREAS

The American Cancer Society estimates that 48,960 cases of pancreatic cancer developed in 2015 in the United States, and the majority of patients (40,560) will die from the disease.⁷ Most patients with adenocarcinoma of the pancreatic head present with obstructive jaundice.⁸

TABLE 2. Pancreatic neoplasia

Primary
Pancreatic neoplasia
Malignant
Exocrine
Pancreatic adenocarcinoma (solid and/or cystic)
Acinar cell
Endocrine
Neuroendocrine tumors
Benign
Exocrine
Solid pseudopapillary tumor
Cystic neoplasms of the pancreas
Endocrine
Neuroendocrine tumors
Metastatic
Unclassified
Lymphoma

Symptoms generally do not occur until advanced disease is present among patients with pancreatic adenocarcinoma involving the body or tail, hence these patients are less likely to have resectable tumors. The endoscopic evaluation of solid pancreatic tumors is directed toward detection, staging, and obtaining a correct tissue diagnosis in cases that are not going directly to surgery. Correct pathologic diagnosis in rare cases of lymphoma or autoimmune pancreatitis mimicking pancreatic cancer might preclude surgery in these patients. Cross-sectional radiologic imaging typically precedes endoscopy in these patients and aids in tumor detection, localization, and determination of resectability.

Radiologic modalities

Transabdominal US. Transabdominal US (TUS) may suggest biliary obstruction by demonstrating biliary ductal dilation. It also may identify the presence of obvious liver metastases. TUS is operator dependent and has a poor sensitivity for detecting small neoplasms of the pancreatic head.⁹ However, recent advances such as color-power Doppler US, contrast-enhanced US, harmonic imaging, and 3-dimensional (3-D) US may improve the utility of this modality in the staging of pancreatic cancer.¹⁰ Contrast-enhanced US is useful in evaluating the real-time vascularity of various pancreatic masses, which may aid in the differential diagnosis of pancreatic mass lesions.¹¹ Nonetheless, more information regarding staging and extent of disease, and possible nodal or vascular involvement, can be obtained with other imaging modalities.

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