

Introduction to a New Series



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Few malignancies have frustrated the persistent efforts of medical professionals involved in evaluating and treating gastrointestinal malignancies like pancreatic cancer. All gastroenterologists will evaluate and treat patients with a pancreatic malignancy as this disease is the second most common gastrointestinal malignancy after colorectal cancer highlighting the need to broaden our knowledge of this disease.

Pancreatic cancer is usually unresectable at the time of diagnosis because of metastasis or local extension. Despite the aggressive nature of this deadly disease, systemic treatment options are limited. Even the recent introduction of the deoxycytidine analogue gemcitabine does not extend median survival beyond 6 months.

The annual incidence and overall number of deaths from pancreatic cancer in the United States are virtually identical; in 2005 an estimated 32,180 new cases will be diagnosed resulting in 31,800 deaths. The majority of pancreatic cancers are at least 3 cm in diameter at initial diagnosis and have already infiltrated the local vasculature; incidental detection occurs in only a small number of patients. As a result, the mortality from this disease almost parallels its incidence, with a 5-year survival rate of less than 10%. Preoperative staging and detection have traditionally relied on transabdominal ultrasonography, computed tomography (CT), and endoscopic retrograde cholangiopancreatography (ERCP). Endoscopic ultrasound with fine needle aspiration (EUS-FNA)

allows preoperative diagnosis and staging of pancreatic adenocarcinoma.

Pancreatic cystic neoplasms are being detected at an increased rate in the current era of sophisticated abdominal imaging. The selection of appropriate treatment depends on the ability to distinguish benign from malignant cysts. The most common clinical mistake is to treat a cystic neoplasm as a benign pseudocyst.

The identification of a cyst as a cystic neoplasm should be suspected on clinical grounds but the differentiation from a benign cyst is often difficult based on clinical features and imaging alone. Analysis of cystic fluid for tumor markers and cytology should be considered, utilizing newer approaches such as endoscopic ultrasound guided—FNA, in those patients in whom this information may guide appropriate therapy.

Treatment options in pancreatic cancer are limited, with surgery offering the only proven long-term cure in a very select few patients. However, newer chemotherapeutic agents and radiation therapy regimens may offer significant survival advantage.

This three-part series will give a broad overview beginning with the burden of pancreatic cancer and the pathologic classifications, focusing mostly on pancreatic adenocarcinoma but will also include some description of neuroendocrine tumors and pancreatic cysts. Diagnosing pancreatic malignancies can be a challenge and will be discussed in detail in the second article with focus on imaging. The series will conclude with a timely review on the latest approach to attacking this deadly disease from a chemoradiation standpoint and offer some insight to future treatment options. ■

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