key points

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Pancreatic ductal adenocarcinoma has a very poor prognosis. The five-year survival rate for pancreatic cancer is 3% in the UK. There has been very little improvement in outcomes over the past 40 years. The combination of an aggressive disease, vague presenting symptoms and insensitive standard diagnostic tests is a key factor contributing to poor outcomes with only 15% of patients with pancreatic cancer having operable disease at diagnosis.

Although pancreatic cancer has a peak incidence in the ninth decade, 37% of patients are under 70 and 14% are under 60 years of age. In patients aged 60 and above, jaundice has a positive predictive value (PPV) of 22%, whereas other symptoms, such as abdominal pain, altered bowel habit or new-onset diabetes, are non-specific with a PPV of less than 1%. However, associated weight loss increases the PPV to between 1.5 and 2.7%.

The NICE guideline on referral for suspected cancer recommends urgent referral via a suspected cancer pathway referral if the patient is aged 40 and over with jaundice. It also recommends that an urgent direct access computerised tomography (CT) scan referral should be considered in patients aged 60 and over with weight loss and any of the following: diarrhoea; back pain; abdominal pain; nausea; vomiting; constipation; new onset diabetes.

Pancreatic cancer requires a CT scan for diagnosis. Although trans-abdominal ultrasound is excellent at detecting gallstones and confirming obstructive jaundice by the presence of bile duct dilatation, the presence of gas in the stomach makes visualisation of the pancreas poor. It is important to consider a CT scan and follow-up appointment for patients with epigastric 'dyspepsia' who have either a normal gastroscopy or symptoms that have not responded to anti-acid therapy. If the diagnosis is unclear, as can happen in autoimmune disease or chronic pancreatitis, or the tumour is unresectable, pancreatic tissue sampling can be performed using endoscopic ultrasound with fine needle aspiration.

There is an increased incidence of pancreatic cancer in a number of conditions including chronic pancreatitis (three fold) and hereditary pancreatitis (50 fold). Surveillance for pancreatic cancer is currently recommended in hereditary pancreatitis, Peutz–Jeghers syndrome and patients with a high-risk gene mutation who have a first-degree relative with pancreatic cancer. Pancreatic cysts are found incidentally on 2.6% of CT scans. Although most cysts are benign or inflammatory, there is a small risk estimated at 0.72% per year of mucinous cysts becoming malignant. Therefore, patients with a pancreatic cyst should be referred to secondary care for characterisation so that a decision can be made regarding further management, based on identified risk factors such as pancreatic duct enlargement.