key points

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Adenocarcinoma of the pancreas is one of the top ten leading causes of cancer deaths and in the UK around 8,000 people are diagnosed with the disease each year. The incidence is similar in men and women and rises with age. Rates increase significantly in people aged 45 years and over and around three-quarters of patients diagnosed with pancreatic cancer are over the age of 65. Overall, the long-term prognosis of the disease is poor with a one-year survival rate of approximately 10-20%.

The presenting symptoms of pancreatic cancer are largely dependent on tumour location. Approximately half of patients are diagnosed with a tumour within the head of the pancreas and many of these will present with jaundice. Around half of patients with carcinoma of the head of pancreas will present with abdominal or back pain, which itself is an independent predictor of poor outcome. Rapid unintentional weight loss should raise clinical suspicion and is associated with shorter survival; and recent onset diabetes may serve as a warning sign.

Individuals with two or more first-degree relatives with pancreatic cancer are at increased risk, even if no gene defect is identified. There are also a number of familial cancer syndromes which, although rare, carry a significantly higher risk. Patients with chronic pancreatitis from any aetiology have an approximately 15-fold higher risk than the general population, while diabetes mellitus, smoking and obesity have relative risks of around 2.

In the UK, patients over the age of 40 with presenting symptoms of unexplained weight loss in combination with upper abdominal or back pain or late onset diabetes, in whom pancreatic cancer is suspected, should be referred for an urgent pancreatic protocol contrast-enhanced CT scan as a first-line investigation. GPs without direct access to CT should refer to a gastroenterologist or surgeon, in line with the two-week cancer target wait.

CT imaging of the chest, abdomen and pelvis provides information on the location of the tumour, its relationship to vascular and other adjacent structures, and the presence or absence of extra-pancreatic disease. The staging of the disease is crucial as it guides further management.

Even after resection, median survival is only 10–20 months and no more than 5–20% of resected patients survive five years. Palliative chemotherapy has been shown to improve quality of life and survival in advanced disease.

In patients with locally advanced or metastatic disease, endoscopic stenting is the accepted initial treatment for the palliation of jaundiced patients. Pancreatic cancer commonly causes gastric outlet obstruction, with an incidence of 10-20%. Relief can be achieved either by surgical bypass or by endoscopic insertion of SEMS. Severe intractable abdominal or back pain is common and patients may require increasing analgesia, as defined by the WHO analgesic ladder, and access to palliative care.