**John B. Amos Cancer Center**

**The 4.6 standard for monitoring compliance with evidence-based guidelines for 2019 is focusing on pancreatic cancer.**

This report will focus on to metrics reported in the NCCN 2016 guidelines.
The first metric is the need to restage with a Ca19-9 and imaging consisting of CT scans and/or the option of a PET scan after definitive surgery.
"Postoperative adjuvant treatment. Baseline pretreatment CT scan, CA 19–9."
"The role of PET/CT remains unclear. PET/CT may be considered after formal pancreatic CT protocol and high-risk patients to detect extra pancreatic metastasis."

The second is the appropriate referral to high-volume centers for pancreatic surgery and staging in cases that were appropriate to such: "Decisions about diagnostic management and resectability should involve multidisciplinary consultation at a high-volume center with the use of appropriate imaging studies."

The third metric will be concordance with initial treatment guidelines in the setting of resectable, borderline resectable, locally advanced unresectable, and stage IV metastatic disease.

**Sources:**
Recorded cases in 2016. Data comes from tumor registry, and individual review of patient record for 38 cases.

**Results:** 38 cases evaluated:

1. 38 cases were reviewed for histology. One was relabeled as duodenal carcinoma as the primary, secondary to initial imaging that could not distinguish a head of pancreas mass from a duodenal mass. The patient had neoadjuvant chemotherapy/FOLFIRINOX with an appropriate diminution in the size of the mass, ultimately undergoing surgery.
A second patient had metastatic paraganglioma, not primary adenocarcinoma of the pancreas
Two other patients patient had a high-grade pancreatic neuroendocrine carcinoma and were treated appropriately, according to histology.

2. Of the remaining cohort of 34 patients, 8 underwent a Whipple procedure, for underwent a partial or distal resection. They were assessed for restaging after resection. Of the 8 patients who had confirmed pancreatic cancer and underwent surgery, 7 underwent restaging before proceeding on with additional therapy.

3. A small cohort of patients (n= 5) required neoadjuvant chemotherapy or had borderline resectable pancreatic masses.
Of these 5, four were discussed at high-volume centers.

4. Of the 34 accessible patients, 5 were either not candidate for chemotherapy or refused therapy upfront.

5. First courses of therapy in the neoadjuvant setting, borderline resectable setting, and adjuvant and metastatic settings were concordant with appropriate types and courses of chemotherapy.

6. The NCCN 2016 guidelines recommend imaging with a dedicated pancreatic protocol or MRI. A pancreatic protocol should include images in the arterial pancreatic parenchymal phase and the portal venous phase. The NCCN guidelines recommend the use of the pancreatic cancer radiology reporting template. The current review of charge and studies showed that 2 imaging studies were reported as such.

**Assessment:** First courses of chemotherapy were concordant with 2016 chemotherapy guidelines. Of the 5 patients who merited discussion at a high-volume center, four were done with appropriate timing to assess resectability and assist with subsequent therapy.
Of the patient's assessed for post resectability imaging, 1 fell outside of the guideline. Of note that patient was imaged 2 weeks after their first course of gemcitabine in the adjuvant setting. That patient was in fact found to have had early metastatic disease.

**Recommendation:** Continued efforts should be made to assess resectability with institutions that are considered high-volume centers (performing more than 15 or 20 pancreatic resections annually). The Piedmont pancreatic cancer consortium is now accessible to the patients within our Columbus catchment and now conducts a weekly pancreatic and hepatobiliary multidisciplinary tumor board. Scheduled presentation of new pancreatic cancer patients is now encouraged. As of September 2019, all pancreatic cancer patients are now formally being reported to a central pancreatic registry in the Atlanta Piedmont office.
The documentation of pancreatic imaging has now been templated for the entire hospital system. The committee well pursue implementation of the pancreatic imaging template for the Piedmont Columbus Regional hub.
All patients are now encouraged to be registered in the multidisciplinary tumor board with information to be sent to the following email address: pancreasTBC@piedmont.org. This would include patient name, diagnosis, and other information that merits review. The data from our stage IV patients is also being collected although will not be formally presented at the MDTB. All other patients are expected to be presented in the upfront treatment setting for discussion of resectability and planning the course of therapy.

Submitted by,

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