Evaluation of diagnostics guidelines for hepatobiliary and pancreatic disease
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Appendix

IKA/IKST guideline for diagnostic workup and treatment of pancreatic carcinoma

Appendix

Introduction

Different national authorities, such as the quality institution for healthcare CBO, scientific societies (e.g. the Dutch general practitioners' society and the Dutch society of surgery) the medical insurance board and the comprehensive cancer centers all develop guidelines. The introduction and the use of these guidelines, their influence on care and the achieved benefit on healthcare have not yet been studied in detail. Most probably some of these consensus guidelines are not just used in general. Active participation in the development of guidelines and feedback are important conditions necessary for the implementation of guidelines.

In 1999 the guideline committee on pancreatic carcinoma, a subcommittee of the tumor work-group gastroenterology of the Comprehensive Cancer Center Amsterdam and Stedendriehoek Twente, prepared a guideline for diagnosis and treatment of pancreatic carcinoma.

Collaboration between the departments of Surgery and clinical Epidemiology of the Academic Medical Center resulted in a guideline development project. In the first part of this project an evaluation was made of the daily practice of diagnostic work-up in all patients with a pancreatic carcinoma in the district of the Comprehensive Cancer Center Amsterdam. A report of this evaluation can be found in chapter 5. During that time the guideline committee pancreatic carcinoma developed a guideline. This committee consisted of a delegation of specialists involved with pancreatic carcinoma from the hospitals in the IKA and IKST regions. The members of the committee were: Ms.B.M.P. Aleman, radiotherapist, NKI C.J. van Groeningen, oncologist AZ-VU; E.J.Hesselink, surgeon ZCA Apeldoorn; S.S.K.S. Phoa, radiologist AMC; E.A.J. Rauws, gastroenterologist AMC; G.van Tienhoven, radiotherapist AMC; D.J. Gouma surgeon AMC. The guideline was based on 'the best available evidence'. The concept guideline was presented to all gastroenterologists, oncologists and surgeons in the regions before the definitive guideline was formulated and distributed. On the following page, the diagnostic flow chart included in the guideline is displayed. It is our conviction that the implementation of guidelines is more successful when the guideline is based on evidence, accepted by the representatives of the specialists in the regions, and when for the formulation of the guideline the local conditions are taken into account which might influence the implementation.

It was tried to satisfy all conditions in the formulation of the guideline. After an implementation period of six months used to integrate the guideline into daily practice, an evaluation of the effects of the guideline was performed which is described in chapter 8.
Summary

Screening
Screening of non-symptomatic patients is not useful, except in hereditary pancreatitis.

Staging
Symptoms: weight loss / pain / jaundice.
Laboratory investigation: liver function; tumor markers not useful.
Radiological investigation: first non-invasive, trans-abdominal ultrasound; no metastasis:
spiral CT
Spiral CT no metastasis / vascular ingrowth found: curative resection
ERCP if biliary drainage need to be ensured (bilirubine > 150 µmol/L)
MRI if visualization of the bile ducts is indicated.
Endosonography when a clinical suspicion of a pancreatic carinoma which cannot be
visualized with ultrasound or spiral CT.
Laparoscopy in pancreas corpus / tail tumors.

Treatment
Curative
Pancreatic head / corpus tumor: pylorus preserving pancreaticoduodenectomy.
Pancreatic tail tumor: pancreatic tail resection.

Palliative
Biliary obstruction: endoprosthesis by means of ERCP, or if this is impossible, PTC/PTD.
When life expectancy > 6 months, duodenum obstruction, or peroperative unresectable
disease than surgical palliation: hepatico-jejunostomy, cholecystectomy, gastro-
jejunostomy and celiac plexus blockade.
Radiotherapy for palliation of pain or bleeding, or in a study context.
Chemotherapy in a study context (gemcitabine).

Follow-up
No follow-up for recurrent disease, only prevention of symptoms.
Treatment of pain: medication, plexus celiac plexus blockade, or thoracal
splanchnicectomy.
Suppletion of pancreatic enzyme.
Treatment of diabetes mellitus.
In case of biliary or gastrointestinal obstruction: bypass.
Figure 1. Flow chart for diagnostic work-up and treatment of pancreatic carcinoma

Appendix