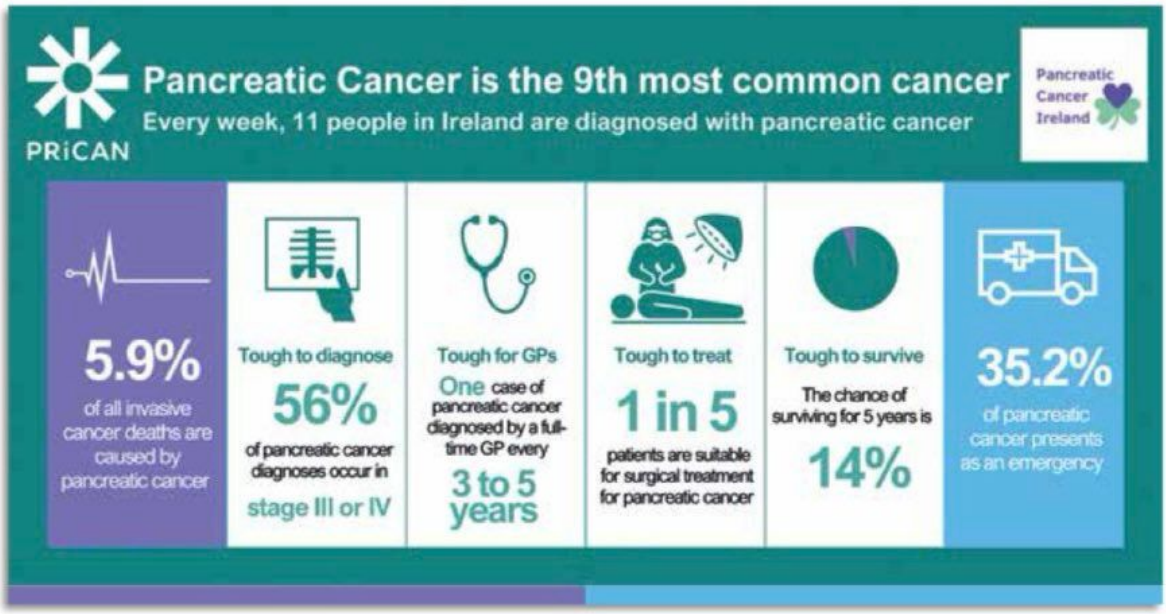
Pancreatic cancer: the role of the GP

By supporting GPs with better diagnostic tools and pathways, we can hope to catch pancreatic cancer earlier and improve outcomes for patients



PANCREATIC CANCER poses significant challenges for GPs due to its poor prognosis, rarity and diagnostic difficulty. Despite being one of the less common cancers, it is one of the deadliest, largely due to its late presentation. Here, we explore the GP's role in diagnosing this disease and potential avenues for earlier detection.

Grim statistics

In Ireland, pancreatic cancer accounts for about 2.4% of cancer cases but has a particularly poor prognosis.[1] While mortality rates for many other cancers in Europe have declined, pancreatic cancer mortality has remained stubbornly high, making it an important public health concern.[2] Over one-third of pancreatic cancer cases in Ireland present as emergencies, and nearly half are diagnosed at stage IV, where the five-year net survival is only 3%.[1] These grim statistics highlight the need for earlier diagnosis to improve patient outcomes.

The diagnostic challenge

A major reason for this poor prognosis is its late presentation.[3] Early symptoms are often non-specific and can easily be attributed to less serious conditions. Common symptoms like abdominal pain, nausea and back pain have low positive predictive values for cancer,[4] often requiring multiple consultations before a diagnosis is made.[5] Jaundice, which has a high predictive value, occurs in only 12-43% of cases, and usually indicates advanced disease.[6] On average, a GP may encounter only one case of pancreatic cancer every five years, underlining its rarity and the difficulty in developing diagnostic expertise.[7]

Current guidelines and their limitations

The current UK National Institute for Health and Care Excellence (NICE) guidelines recommend referring patients over 40 with jaundice via a suspected cancer pathway and considering urgent CT or ultrasound for patients over 60 with weight loss and other less specific symptoms.[8] However, these guidelines do not address patients under 40 or those presenting with vague symptoms,leaving a significant gap in early diagnosis efforts. Studies have shown that over 50% of cancer patients present with vague symptoms that would not trigger a referral under existing guidelines.[9]

Improving early detection

We believe early detection of pancreatic cancer must occur in the community setting to improve outcomes. One of the objectives of the National Cancer Control Programme (NCCP) Early Diagnosis of Cancer Plan is to support community healthcare professionals in recognising and referring people with signs/symptoms of cancer.[10] GPs need new tools to combat the diagnostic challenge of early cancer presentations.

Potential tools for early diagnosis

Risk identification based on primary care record

Worsening blood glucose control in known or new-onset diabetes can indicate pancreatic cancer but is often overlooked.[11] Risk models and clinical decision tools like QCancer

in the UK have been developed, but their routine clinical utility needs further evaluation.[12,13] Additionally, the implementation of machine learning tools based on primary care data show promise and warrant further investigation.[14,15]

Multi-cancer early diagnostic tools (MCEDs) and biomarkers

Tools like the Galleri test show promise in early cancer detection but require further evaluation for performance and clinical utility.[16] The pancreatic cancer blood biomarker CA 19-9 is underutilised due to limited evidence of its effectiveness and potential diagnostic inaccuracies. Further research into its utility in primary care is needed.[17]

Non-specific symptom pathways

The UK has trialled a dedicated urgent non-specific symptom (NSS) pathway, demonstrating a 7% overall cancer conversion rate, including 43 cases of pancreatic cancer.[18] Symptoms prompting referral included unexplained weight loss, pain, loss of appetite and fatigue. This approach, which considers 'symptom clusters', could streamline referrals and prompt earlier diagnoses. Ireland should consider developing similar NSS pathways.

Conclusion

Innovative methods to improve early diagnosis of pancreatic cancer in the primary care setting are critical to reduce its mortality burden. Tools like MCEDs and AI-based decision aids show promise but require further research. The NSS pathway trialled in the UK has demonstrated value and could be a model for Ireland to follow. By supporting GPs with better diagnostic tools and pathways, we can hope to catch this silent killer earlier and improve outcomes for patients.

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